COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE MANUAL

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: June 24, 2020 Abuse & Neglect.P6

RESCINDS: June 28, 2017

CATEGORY: Recipient Rights

SUBJECT: Abuse and Neglect

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that recipients of services shall be protected from abuse or neglect. Abuse or neglect of a recipient by an employee, volunteer, or agent of a provider shall subject the employee, volunteer, or agent of a provider, upon substantiated reports, to an appropriate penalty, including official reprimand, demotion, suspension, reassignment, or dismissal. Allegations of abuse or neglect will be promptly and thoroughly reviewed in a manner that is fair to both the recipient alleged to have been abused or neglected and the employee, volunteer, or agent of a provider alleged to have carried out the abuse or neglect.

PURPOSE: To define abuse and neglect and to establish detailed categories of each by type and severity, to establish procedures for reporting allegations, investigating allegations, and for remediation of substantiated allegations.

DEFINITIONS:

Abuse: Non-accidental physical or emotional harm to a recipient, or sexual contact with or sexual penetration of a recipient as those terms are defined in section 520a of the Michigan penal code, that is committed by an employee or volunteer of the community mental health services program, or an employee or volunteer of a service provider under contract with the community mental health services program.

Abuse, Class I: A non-accidental act, or provocation of another to act, by an employee, volunteer, or agent of a provider that causes or contributes to the death, or sexual abuse of, or serious physical harm to a recipient.

Abuse, Class II: A non-accidental act, or provocation of another to act by an employee, volunteer, or agent of a provider that causes, or contributes to non-serious physical harm to a recipient; or,

The use of unreasonable force on a recipient by an employee, volunteer, or agent of a provider with or without apparent harm; or,

Any action, or provocation of another to act by an employee, volunteer, or agent of a provider that causes, or contributes to emotional harm to a recipient; or,

An action taken on behalf of a recipient by a provider who assumes the recipient is incompetent, despite the fact that a guardian has not been appointed, that results in substantial economic, material, or emotional harm to the recipient; or,

Exploitation of a recipient by an employee, volunteer, or agent of a provider.

Abuse, Class III: The use of language or other means of communication by an employee, volunteer, or agent of a provider to degrade, threaten, or sexually harass a recipient.

Neglect: An act or failure to act committed by an employee or volunteer of a community mental health services program, a service provider under contract with the community mental health services program, or an employee or volunteer of a service provider under contract with a community mental health services program, that denies a recipient the standard of care or treatment to which he or she is entitled under the Mental Health Code.

Neglect, Class I: Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by laws, rules, policies, guidelines, written directives, procedures, and/or individual plans of service and causes or contributes to the death, or sexual abuse of, or serious physical harm to a recipient; or,

The failure to report apparent or suspected abuse Class I or neglect Class I of a recipient.

Neglect, Class II: Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by laws, rules, policies, guidelines, written directives, procedures, and/or individual plans of service and causes or contributes to non-serious physical harm or emotional harm to a recipient; or,

The failure to report apparent or suspected abuse Class II or neglect Class II of a recipient.

Neglect, Class III: Acts of commission or omission by an employee, volunteer, or agent of a provider that result from noncompliance with a standard of care or treatment required by laws, rules, policies, guidelines, written directives, procedures, and/or individual plans of service that either placed or could have placed a recipient at risk of physical harm or sexual abuse; or,

The failure to report apparent or suspected abuse Class III or neglect Class III of a recipient.

Criminal Abuse: One or more of the following:

An assault that is a violation or an attempt or conspiracy to commit a violation of sections 81 to 90 of the Michigan penal code, Act No. 328 of the Public Acts of 1931, being sections 750.81 to 750.90 of the Michigan Compiled Laws. Criminal abuse does not include an assault or an assault and battery that is a violation of section 81 of Act No. 328 of the Public Acts of 1939, being section 750.81 of the Michigan Compiled Laws, and that is committed by a recipient against another recipient.

A criminal homicide that is a violation or an attempt or conspiracy to commit a violation of section 316, 317, or 321 of Act No. 328 of the Public Acts of 1931, being sections 750.316, 750.317, and 750.321 of the Michigan Compiled Laws.

Criminal sexual conduct that is a violation or an attempt or conspiracy to commit a violation of sections 520b to 520e or 520g of Act No. 328 of the Public Acts of 1931, being sections 750.520b to 750.520e and 750.520g of the Michigan Compiled Laws.

Vulnerable adult abuse that is a violation or an attempt or conspiracy to commit a violation of section 145n of the Michigan Compiled Laws.

Child abuse that is a violation or an attempt or conspiracy to commit a violation of section 136b of Act No. 328 of the Public Acts of 1931, being section 750.136b of the Michigan Compiled Laws. (Attachment A: Exhibit A: Abuse as defined by the Michigan Penal Code. Exhibit B: Vulnerable adult abuse as defined by the Michigan Penal Code. Exhibit C: Child abuse as defined by the Michigan Penal Code.)

Act: Mental Health Code, 1974 PA 258, MCL 330.

Anatomical Support: Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.

Bodily Function: The usual action of any region or organ of the body.

Degrade: means any of the following:

A. To treat humiliatingly.

B. To cause somebody or something a humiliating loss of status or reputation.

C. To cause somebody a humiliating loss of self-esteem, make worthless.

D. To cause people to feel that they or other people are worthless and do not have the respect or good opinion of others.

Emotional Harm: Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.

Employee: An individual who works for Copper Country Mental Health Services and receives compensation for that work.

Exploitation: An action by an employee, volunteer, or agent of a provider that involves the misappropriation or misuse of a recipient's property or funds for the benefit of an individual or individuals other than the recipient.

Non-Serious Physical Harm: Physical damage or what could reasonably be construed as pain suffered by a recipient that a physician or RN determines could not have caused or contributed to, the death of a recipient, the permanent disfigurement of a recipient, or an impairment of his/her bodily function(s).

Office Of Recipients Rights: That office, as established in the Mental Health Code (PA 290 of 1995) which is subordinate only to the chief official of the agency establishing it and which is responsible for rights protection and advocacy services.

Physical Management: A technique used by a trained employee as an emergency intervention to restrict the movement of a recipient by direct physical contact in order to prevent the recipient from physically harming himself/herself, or others.

Physical management shall only be used on an emergency basis when a recipient or the situation is presenting an imminent risk of serious or non-serious physical harm to himself/herself or others and when lesser restrictive interventions have been unsuccessful in reducing or eliminating the imminent risk of physical harm. Physical management shall not be included as a component in a behavior treatment plan. **PRONE IMMOBILIZATION OF A RECIPIENT FOR THE PURPOSE OF BEHAVIOR CONTROL IS PROHIBITED UNDER ANY CIRCUMSTANCES.**

Protective Device: A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined here and incorporated in the written individual plan of service shall not be considered a "restraint" as defined below.

Recipient: An individual who receives mental health services from the Michigan Department of Health and Human Services, a community mental health services program, or a facility or from a provider that is under contract with the department or a community mental health services program.

Restraint: The use of a physical or mechanical device, material, or equipment to restrict an individual's movement; specifically, anything that immobilizes or reduces the ability of the recipient to move his/her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the individual or others at risk of physical harm. Restraint does not include the use of a device primarily intended to provide anatomical or physical support that is ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving an individual's physical functioning; or safety devices required by law, such as car seat belts or child car seats used in vehicles.

THE USE OF PHYSICAL OR MECHANICAL DEVICES USED AS RESTRAINT IS PROHIBITED IN ALL AGENCY PROGRAMS UNDER ANY CIRCUMSTANCES.

Serious Physical Harm: Physical damage suffered by a recipient that a physician or RN determines caused or could have caused the death of a recipient, caused the impairment of his/her bodily function(s), or caused the permanent disfigurement of a recipient.

Sexual Abuse: Any of the following:

Criminal sexual conduct as defined by section 520b to 520 e of 1931 PA 318, MCL 750.520b to MCL 750.520e involving an employee, volunteer, or agent of a provider and a recipient; or,

Any sexual contact or sexual penetration involving an employee, volunteer, or agent of an adult foster care facility and a recipient; or,

Any sexual contact or sexual penetration involving an employee, volunteer, or agent of a provider and a recipient for whom the employee, volunteer, or agent provides direct services.

Sexual Contact: The intentional touching of the recipient's or employee's intimate parts (genitals, buttocks, breasts, groin, inner thigh or rectum) or the touching of the clothing covering the immediate area of the recipient's or employee's intimate parts, if that intentional touching can be reasonably construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for any of the following:

A. Revenge
B. To inflict humiliation
C. Out of anger

Sexual Harassment: Sexual advances to a recipient, requests for sexual favors from a recipient, or other conduct or communication of a sexual nature toward a recipient.

Sexual Penetration: Sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a recipient's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.

Threaten: means any of the following:

A. To utter intentions of injury or punishment against:

B. To express a deliberate intention to deny the well-being, safety, or happiness of somebody unless the person does what is being demanded.

Unreasonable Force: Physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances:

A. There is no imminent risk of serious or non-serious physical harm to the recipient, employee or others;

B. The physical management used is not in compliance with techniques approved by the Agency;

C. The physical management used is not in compliance with the emergency interventions authorized in the recipient's Individual Plan of Service;

D. The physical management or force is used when other less restrictive measures were possible, but not attempted immediately before the use of physical management or force.

Volunteer: An individual who, without compensation, other than reimbursement for expenses, performs activities for the department, a facility, or a community mental health services program, or an entity under contract to the department, a facility, or a community mental health services program under specified conditions.

STANDARDS:

I. All employees are responsible for safeguarding recipients from abuse or neglect. It is the assigned duty and legal responsibility of an employee who has knowledge of recipient abuse, or neglect to make or cause to be made a report to the local law enforcement agency, (county or city in which the violation is suspected to have occurred), state police or Department of Health and Human Services (county in which violation is alleged to occur) when appropriate.

In all cases of abuse, neglect and/or mistreatment, it is the assigned duty and responsibility of the employee who has knowledge of or reasonable cause to suspect recipient abuse, neglect, and mistreatment to report it to their immediate supervisor/designee, and to the Recipient Rights Office.

II. Allegations of abuse, or neglect shall be reported in accordance with Recipient Rights procedures, related to Copper Country Mental Health Services policies, and state law.

III. When a prompt and thorough initial review has determined that there is cause to believe or suspect that child abuse or neglect has or may have occurred, the reporting employee shall notify his/her supervisor/designee, Department of Health and Human Services and CCMHS Office of Recipient Rights. In all cases of suspected criminal abuse or neglect (child or adult) the appropriate police agency shall also be notified.

IV. During police investigation of alleged abuse:

A. Police shall be given full cooperation and support by direct service and contract service agency personnel in order that they may complete their investigation.

B. The investigation convened by the Office of Recipient Rights shall be carried out in cooperation with the police.

V. All contracts for services to recipients, with agencies and other providers include the requirement of compliance with all recipient rights provisions of the Mental Health Code and Administrative Rules.

VI. When there is reasonable cause to suspect that an employee, either directly or as an accomplice, has been involved in abuse or neglect of a recipient, the employee will not continue in his/her present assignment during the investigation of allegation(s).

VII. Assistance will be provided to appropriate individuals and/or agencies as necessary in the prosecution of criminal charges against those who have engaged in abuse, including the reporting of acts of actions which may lead to prosecution. Copper Country Mental Health Services Board employees shall cooperate with authorized investigators from other agencies assigned to inquire into other violations which by law are within their jurisdiction, for example, the Michigan Department of Civil Rights, Protective Services, and Department of Health and Human Services.

REPORTING/INVESTIGATION PROCEDURES:

I. All allegations or incidents of suspected abuse, neglect, mistreatment toward a recipient shall be reported to the employee's immediate supervisor/designee and to the Copper Country Mental Health Office of Recipient Rights.

II. When necessary, pursuant to P.A. 32 Section 723, a verbal report shall be made immediately to the law enforcement agency for the county or city in which the abuse is suspected to have occurred or to the state police. Within 72 hours after making the oral report to the appropriate law enforcement agency, the reporting employee shall file a written report. The written report shall be filed with the law enforcement agency to which the oral report was made, and with the Copper Country Mental Health Office of Recipient Rights. If the employee making the report is not the person making the initial allegation, that person shall be provided a copy of the written report.

A. A report of suspected abuse is not required if the employee has knowledge (must be clearly documented) that the incident has been reported to the appropriate law enforcement agency, or suspected abuse occurred more than one (1) year before the date on which it first became known to an employee otherwise required to make a report.

B. The written reports contain the name of the recipient, a description of the abuse and other available information which might establish the cause and manner of the alleged abuse. This report becomes part of the recipient's clinical record. Upon placement in the clinical record the names of the reporting person and the person accused of committing the alleged abuse are deleted.

C. The identity of the individual making a report and the report itself is confidential and is disclosed only with the written consent of the individual or by appropriate judicial process.

D. These reporting requirements do not relieve an employee from the duty to report abuse under other applicable law.

III. The reporting requirement is superseded by the recipient-therapist (psychiatrist, psychologist, clinical social worker, licensed counselor) privilege recognized in the State of Michigan if the allegation does not involve:

A. Abuse by (1) a mental health professional, (2) a person employed by or under contract to the Department of Health and Human Services, a facility, or a community mental health board, or (3) a

person employed by an entity under contract to the Department, a facility, or a community mental health board; or

B. If the suspected abuse is alleged to have been committed in (1) a facility, (2) a community mental health program site, (3) the work site of a person employed by or under contract to a facility to community mental health board, or (4) an entity under contract to a facility or community mental health board, or (5) any place where a recipient is under the supervision of a person employed by or under contract to a facility or community mental health board, or (6) an entity under contract to a facility or community mental health board.

IV. Upon receipt of written notification of alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation an investigation shall be initiated immediately by the Office of Recipient Rights. The Office of Recipient Rights shall notify the Executive Director or designee of the situation, keeping the Director apprised of the investigation (if warranted) and the findings. Assure that appropriate procedures for notification to various departments and law enforcement agencies are completed.

V. Investigations of allegations of abuse or neglect are carried out in compliance with the Rights Complaints/Appeals Policy.

CROSS REFERENCE:

CCMHS Policy - Rights Complaints/Appeals

Mental Health Code

Department of Health and Human Services Administrative Rules

Michigan Penal Code - as cited

Exhibit A: Abuse as defined by the Michigan Penal Code

I. Violations of Sections 81 to 90 of the Michigan Penal Code; including an attempt or a conspiracy to commit a violation of Sections 81 to 90.

Note: Abuse does not include an assault which is a violation of Section 81 of the Michigan Penal Code committed by a recipient or resident against another recipient or resident unless the battery results in serious physical injury.

Note: A brief explanation of the violation follows each section where necessary for the sake of understanding. These explanations are not exact definitions from the Penal Code.

750.81 Assault/Assault and Battery

Assault - Any willful attempt or threat to inflict injury upon the person of another when coupled with an apparent present ability to do so and any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm.

Assault and battery - Any unlawful touching of another which is without justification or excuse. Battery requires physical contact of some sort (bodily injury or offensive touching).

750.81A Aggravated Assault

An assault committed with the intention of committing some additional crime or one attended with circumstances of peculiar outrage or atrocity. A person is guilty of aggravated assault if he/she:

(a) attempts to cause serious bodily injury to another, or causes such injury purposely, knowingly or recklessly under circumstances manifesting extreme indifference to the value of human life; or

(b) attempts to cause or purposely or knowingly causes bodily injury to another with a dangerous or deadly weapon.

750.82 Felonious Assault (Deadly Weapon)

An unlawful attempt or offer to do bodily harm without justification or excuse by use of an instrument calculated to do harm or cause death. An aggravated form of assault as distinguished from a simple assault, e.g., pointing a loaded gun at another is an assault with a dangerous/deadly weapon.

750.83 Assault With Intent to Murder

To constitute this assault, specific intent to kill, actuated by malice aforethought must occur.

750.84 Assault With Intent to Do Great Bodily Harm Less Than Murder

750.86 Assault With Intent to Maim

An assault which inflicts upon another any injury which deprives that person of the use of any limb or member of the body; or to seriously disfigure or disable.

750.87 Assault With Intent to Commit (A Felony)

An example would be inflicting bodily injury with an accompanying intent to kidnap or rape the victim.

750.88 Assault With Intent to Rob While Unarmed

750.89 Assault With Intent to Rob While Armed

II. Criminal homicide in violation of Sections 316, 317, or 321 of the Michigan Penal Code, including an attempt or a conspiracy to commit a violation of Sections 316, 317, or 321.

750.316 First Degree Murder

All murder which shall be perpetrated by means of poison, or by lying in wait, or by any other kind of willful, deliberate and premeditated killing, or which shall be committed in the perpetration of, or attempt to perpetrate any arson, rape, robbing or burglary are commonly deemed murder of the first degree.

750.317 Second Degree Murder

All other kinds of murder not deemed in the first degree.

750.321 Manslaughter

The unlawful killing of a human without malice and without premeditation and deliberation.

ATTACHMENT A

III. Criminal sexual conduct in violation of Sections 520b to 520e, or assault with intent to commit criminal sexual conduct in violation of Section 520g of the Michigan Penal Code, including an attempt or conspiracy to commit a violation of Sections 520b through 520e or Section 520g.

Criminal Sexual Conduct as defined under the Michigan Penal Code

750.520a. Definitions

a. "Actor" means a person accused of criminal sexual conduct.

b. "Developmental Disability" means an impairment of general intellectual functioning or adaptive behavior which meets the following criteria:

i.) It originated before the person became 18 years of age,

ii.) It has continued since its origination or can be expected to continue indefinitely,

iii.) It constitutes a substantial burden to the impaired person's ability to perform normally in society,

iv.) It is attributable to one or more of the following:

(A) Mental retardation, cerebral palsy, epilepsy, or autism.

(B) Any other condition of a person found to be closely related to mental retardation because it produces a similar impairment or requires treatment and services similar to those required for a person who is mentally retarded.

c. "Intimate parts" include the primary genital area, groin, inner thigh, buttock, or breast of a human being.

d. "Mental health professional" means that term as defined in section 100b of the mental health code, 1974 PA 258, MCL 330.1100b.

e. "Mental illness" means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

f. "Mentally disabled" means that a person has mental illness, is mentally retarded, or has a developmental disability.

g. "Mentally incapable" means that a person suffers from a mental disease or defect which renders that person temporarily or permanently incapable or appraising the nature of his or her conduct.

h. "Mentally incapacitated" means that a person is rendered temporarily incapable of appraising or controlling his or her conduct due to the influence of a narcotic, anesthetic, or other substance administered to that person without his or her consent, or due to any other act committed upon that person without his or her consent.

i. "Mentally retarded" means significantly subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

j. "Physically helpless" means that a person is unconscious, asleep, or for any other reason is physically unable to communicate unwillingness to an act.

k. "Personal injury" means bodily injury, disfigurement, mental anguish, chronic pain, pregnancy, disease, or loss or impairment of a sexual or reproductive organ.

l. "Sexual contact" includes the intentional touching of the victim's or actor's intimate parts or the intentional touching of the clothing covering the immediate area of the victim's or actor's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or in a sexual manner for:

   i.) Revenge.

   ii.) To inflict humiliation.

   iii.) Out of anger.

m. "Sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings or another person's body, but emission of semen is not required.

n. "Victim" means the person alleging to have been subjected to criminal sexual conduct.

750.520b <u>1st Degree CSC</u>

1.) A person is guilty of criminal sexual conduct in the first degree if he or she engages in sexual penetration with another person and if any of the following circumstances exists:

   a) That other person is under 13 years of age.

   b) That other person is at least 13 but less than 16 years of age and any of the following:

      i.) The actor is a member of the same household as the victim.

ii.) The actor is related to the victim by blood or affinity to the fourth degree.

iii.) The actor is in a position of authority over the victim and used this authority to coerce the victim to submit.

c) Sexual penetration occurs under circumstances involving the commission of any other felony.

d) The actor is aided or abetted by one or more persons and either of the following circumstances exists:

i.) The actor knows or has reason to know that the victim is mentally incapable, mentally incapacitated, or physically helpless.

ii.) The actor uses force or coercion to accomplish the sexual penetration. Force or coercion includes, but is not limited to, any of the circumstances listed in subdivision (f)(i) to (v).

e) The actor is armed with a weapon, or any article used or fashioned in a manner to lead the victim to reasonably believe it to be a weapon.

f) The actor causes personal injury to the victim and force or coercion is used to accomplish the sexual penetration. Force or coercion includes, but is not limited to, any of the following circumstances:

i.) When the actor overcomes the victim through the actual application of physical force or physical violence.

ii.) When the actor coerces the victim to submit by threatening to use force or violence on the victim, and the victim believes that the actor has the present ability to execute these threats.

iii.) When the actor coerces the victim to submit by threatening to retaliate in the future against the victim, or any other person, and the victim believes that the actor has the ability to execute this threat. As used in this subdivision, "to retaliate" includes threats of physical punishment, kidnapping, or extortion.

iv.) When the actor engages in the medical treatment or examination of the victim in a manner or for purposes which are medically recognized as unethical or unacceptable.

v.) When the actor, through concealment or by the element of surprise, is able to overcome the victim.

g) The actor causes personal injury to the victim, and the actor knows, or has reason to know, that the victim is mentally incapable, mentally incapacitated, or physically helpless.

h) That other person is mentally incapable, mentally disabled, mentally incapacitated, or physically helpless, and any of the following;

i.) The actor is related to the victim by blood or affinity to the fourth degree.

ii.) The actor is in a position of authority over the victim and used this authority to coerce the victim to submit.

2.) Criminal sexual conduct in the first degree is a felony punishable by imprisonment in the state prison for life or any term of years.

750.520c 2nd Degree CSC

1.) A person is guilty of criminal sexual conduct in the second degree if the person engages in sexual contact with another person and if any of the following circumstances exists:

a) That person is under 13 years of age.

b) That other person is at least 13 but less than 16 years of age and any of the following:

i.) The actor is a member of the same household as the victim.

ii.) The actor is related by blood or affinity to the fourth degree to the victim.

iii.) The actor is in a position of authority over the victim and the actor used this authority to coerce the victim to submit.

c) Sexual contact occurs under circumstances involving the commission of any other felony.

d) The actor is aided or abetted by one or more other persons and either of the following circumstances exists:

i.) The actor knows or has reason to know that the victim is mentally incapable, mentally incapacitated, or physically helpless.

ii.) The actor uses force or coercion to accomplish the sexual contact. Force or coercion includes, but is not limited to, any of the circumstances listed in sections 520b(1)(f)(i) to (v).

e) The actor is armed with a weapon, or any article used or fashioned in a manner to lead a person to reasonably believe it to be a weapon.

f) The actor causes personal injury to the victim and force or coercion is used to accomplish the sexual contact. Force or coercion includes, but is not limited to, any of the circumstances listed in Sections 520b(1)(f)(i) to (v).

g) The actor causes personal injury to the victim and the actor knows, or has reason to know, that the victim is mentally incapable, mentally incapacitated, or physically helpless.

h) That other person is mentally incapable, mentally disabled, mentally incapacitated, or physically helpless, and any of the following;

i.) The actor is related to the victim by blood or affinity to the fourth degree.

ii.) The actor is in a position of authority over the victim and used this authority to coerce the victim to submit.

2.) Criminal sexual conduct in the second degree is a felony punishable by imprisonment for not more than 15 years.

750.520d 3rd Degree CSC

1.) A person is guilty of criminal sexual conduct in the third degree if the person engages in sexual penetration with another person and if any of the following circumstances exists:

a) That other person is at least 13 years of age and under 16 years of age.

b) Force or coercion is used to accomplish the sexual penetration. Force or coercion includes, but is not limited to, any of the circumstances listed in section 520b(1)(f)(i) to (v).

c) The actor knows, or has reason to know, that the victim is mentally incapacitated, or physically helpless.

2.) Criminal sexual conduct in the third degree is a felony punishable by imprisonment for not more than 15 years.

750.520e 4th Degree CSC

1.) A person is guilty of criminal sexual conduct in the fourth degree if he or she engages in sexual contact with another person and if either of the following circumstances exists:

a) That other person is at least 13 years of age but less than 16 years of age, and the actor is 5 or more years older than that other person.

b) Force or coercion is used to accomplish the sexual contact. Force or coercion includes, but is not limited to, any of the following circumstances:

i.) When the actor overcomes the victim through the actual application of physical force or physical violence.

ii.) When the actor coerces the victim to submit by threatening to use force or violence on the victim, and the victim believes that the actor has the present ability to execute these threats.

iii.) When the actor coerces the victim to submit by threatening to retaliate in the future against the victim, or any other person, and the victim believes that the actor has the ability to execute that threat. As used in this subparagraph, "to retaliate" includes threats of physical punishment, kidnapping, or extortion.

iv.) When the actor engages in the medical treatment or examination of the victim in a manner or for purposes which are medically recognized as unethical or unacceptable.

v.) When the actor achieves the sexual contact through concealment or by the element of surprise.

c) The actor knows, or has reason to know, that the victim is mentally incapable, mentally incapacitated, or physically helpless.

d) That other person is related to the actor by blood or affinity to the third degree and the sexual contact occurs under circumstances not otherwise prohibited by this chapter.

e) The actor is a mental health professional and the sexual contact occurs during or within 2 years after the period in which the victim is his or her client or patient and not his or her spouse. The consent of the victim is not a defense to a prosecution under this subdivision. This does not indicate that the victim is mentally incompetent.

2.) Criminal sexual conduct in the fourth degree is a misdemeanor punishable by imprisonment for not more than two years, or by a fine of not more than $500.00 or both.

ATTACHMENT A

Exhibit B: Vulnerable Adult Abuse as defined by the Michigan Penal Code

750.145m Definitions

a. "Caregiver" means an individual who directly cares for or has physical custody of a vulnerable adult.

b. "Personal care" means assistance with eating, dressing, personal hygiene, grooming, or maintenance of a medication schedule as directed and supervised by a vulnerable adult's physician.

c. "Physical harm" means any injury to a vulnerable adult's physical condition.

d. "Reckless act or reckless failure to act" means conduct that demonstrates a deliberate disregard of the likelihood that the natural tendency of the act or failure to act is to cause physical harm, serious physical harm, or serious mental harm.

e. "Serious physical harm" means a physical injury that threatens the life of a vulnerable adult, that causes substantial bodily disfigurement, or that seriously impairs the functioning or well-being of the vulnerable adult.

f. "Vulnerable adult" means 1 or more of the following:

i.) An individual age 18 or over who, because of age, developmental disability, mental illness, or physical disability requires supervision or personal care or lacks the personal and social skills required to live independently.

ii.) An adult as defined in section 3(1)(b) of the adult foster care facility licensing act, MCL 400.703.

iii.) An adult as defined in section 11(b) of the social welfare act, MCL 400.11.

750.145n. Vulnerable Adult Abuse

1.) A caregiver is guilty of vulnerable adult abuse in the first degree if the caregiver intentionally causes serious physical harm or serious mental harm to a vulnerable adult. Vulnerable adult abuse in the first degree is a felony punishable by imprisonment for not more than 15 years or a fine of not more than $10,000.00, or both.

2.) A caregiver or other person with authority over the vulnerable adult is guilty of vulnerable adult abuse in the second degree if the reckless act or reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes serious physical or serious mental harm to a vulnerable adult. Vulnerable adult abuse in the second degree is a felony punishable by imprisonment for not more than 4 years or a fine of not more than $5000.00, or both.

ATTACHMENT A

3.) A caregiver is guilty of vulnerable adult abuse in the third degree if the caregiver intentionally causes physical harm to a vulnerable adult. Vulnerable adult abuse in the third degree is a misdemeanor punishable by imprisonment for not more than 2 years or a fine of not more than $2500.00, or both.

4.) A caregiver or other person with authority over the vulnerable adult is guilty of vulnerable adult abuse in the fourth degree if the reckless act or the reckless failure to act of the caregiver or other person with authority over the vulnerable adult causes physical harm to a vulnerable adult. Vulnerable adult abuse in the fourth degree is a misdemeanor punishable by imprisonment of not more than 1 year or a fine of not more than $1000.00, or both.

5.) This section does not prohibit a caregiver or other person with authority over a vulnerable adult from taking reasonable action to prevent a vulnerable adult from being harmed or from harming others.

6.) This section does not apply to an act or failure to act that is carried out pursuant to a durable power of attorney for healthcare executed in accordance with section 496 of the revised probate code, P. A. 642 of 1978, being section 700.496 of the Michigan Compiled Laws.

ATTACHMENT A

Exhibit C: Child Abuse as defined by of the Michigan Penal Code

136b Definitions; child abuse.

1.) As used in this section:

a) "Child" means a person who is less than 18 years of age and is not emancipated by the operation of law as provided in section 4(1) of Act 293 of the Public Acts of 1968, being section 722.4 of the Michigan Compiled Laws.

b) "Omission" means a willful failure to provide the food, clothing, or other shelter necessary for a child's welfare, or the willful abandonment of a child.

c) "Person" means a child's parent or guardian or any other person who cares for, or has custody of, or has authority over a child regardless of the length of time that a child is cared for, in the custody of, or subject to the authority of that person.

d) "Physical harm" means any injury to a child's physical condition.

e) "Serious physical harm" means an injury of the child's physical condition or welfare that is not necessarily permanent but constitutes substantial bodily disfigurement, or seriously impairs the function of a body organ or limb.

f) "Serious mental harm" means an injury to a child's mental condition or welfare that is not necessarily permanent but results in visibly demonstrable manifestations of a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

2.) A person is guilty of child abuse in the first degree if a person knowingly or intentionally causes serious physical or serious mental harm to a child. Child abuse in the first degree is a felony punishable by imprisonment for not more than 15 years.

3.) A person is guilty of child abuse in the second degree if the person's omission causes serious physical or serious mental harm to a child or if the person's reckless act causes serious physical harm to a child. Child abuse in the second degree is a felony punishable by imprisonment for not more than 4 years.

4.) A person is guilty of child abuse in the third degree if the person knowingly or intentionally causes physical harm to a child. Child abuse in the third degree is a misdemeanor punishable by imprisonment for not more than 2 years.

5.) A person is guilty of child abuse in the fourth degree if the person's omission or reckless act causes physical harm to a child. Child abuse in the fourth degree is a misdemeanor punishable by imprisonment for not more than 1 year.

6.) This section shall not be construed to prohibit a parent or guardian, or other person permitted by law, or authorized by the parent or guardian, from taking steps to reasonably discipline a child, including the use of reasonable force.

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: February 28, 2024 Access to Services.P11

RESCINDS: May 31, 2023

CATEGORY: Client Services

SUBJECT: Access to Services

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) to assist all Michigan residents who contact the Agency, regardless of where they live. Further, the Agency provides timely access to appropriate and necessary services to all persons with mental illness, serious emotional disturbances, intellectual/developmental disabilities and/or co-occurring substance use disorder who meet eligibility criteria. The process of accessing services is expected to be available, accessible and welcoming to all persons on the telephone and on a walk-in basis. NorthCare Network manages the Access to SUD treatment services.

PURPOSE: This policy outlines requirements to comply with the Michigan Department of Health and Human Services (MDHHS) contract and Access System Standards [Please reference the MDHHS Policies & Practices Guidelines, Access Standards https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines].

DEFINITIONS:

Emergent Situations: Those clinical presentations which involve real and imminent danger to the person or others and which require immediate diagnosis and treatment.

Routine: Those situations in which the person appears to have a mental illness, and/or an intellectual/developmental disability with or without a co-occurring substance use disorder and presents as relatively stable and able to function in their current environment; but may require services to improve functioning in one or more settings, and/or to alleviate emotional distress, and/or to address significant behavioral disturbances, and/or to maintain functioning in the least restrictive setting.

PROCEDURE:

I. Key functions of CCMHS staff that have first contact, either by phone or in person, with someone requesting services are as follows:

   A. Welcome all persons requesting services by demonstrating empathy, providing opportunity for the person to describe his/her situation, problems and functioning difficulties, exhibiting excellent customer service skills, and working with them in a non-judgmental way.

   B. Screen people who approach the access system to determine whether they are in an emergent situation.

   C. If the person is in an emergency situation, assure that they receive timely, appropriate attention by a staff member certified and trained in emergency response. A person who is in real and imminent

danger to self or others should receive immediate response without requiring an individual to call back.

D. If the person requests routine services during normal business hours, connect the person to the Access support staff who will gather demographic information and schedule the individual for an Access Screening with a CCMHS Access screener. Screenings are typically scheduled on the same day but may be scheduled on the next business day.

This initial telephone screening completed by CCMHS determines the person's eligibility for assessment for on-going services, identifies demographics, referral information (including whether or not the person is referred by a primary EPSDT screener) and potential funding sources. A person with Medicaid or Healthy Michigan who is potentially eligible for Specialty Mental Health services is then scheduled for an assessment (i.e. intake) at the appropriate CCMHS office.

Those persons who do not have Medicaid or Healthy Michigan and who are found eligible for an assessment at CCMHS will receive a review according to the CCMHS Waiting List policy. This interview will determine symptom severity/functional impairment and their level of need before any determination of additional service authorization will be rendered.

If a person does not meet eligibility criteria for services, the CCMHS Access staff will provide both an Adverse Benefit Determination and Second Opinion Notice for services and will refer the person to community resources that may meet their needs. The Adverse Benefit Determination will include contact information and instructions on due process. The person will be verbally notified of their right to request a Second Opinion.

E. Assess the need for Limited English Proficiency assistance and other reasonable accommodations, and facilitate accommodations for those identified needs in a timely manner.

II. Emergency Services are available 24 hours a day to all persons in the four-county area. During regular business hours, persons in emergent situations, or someone on his/her behalf, can call CCMHS at 906-482-9404 or 1-800-526-5059, or request services in person at any of the CCMHS clinics, or at any of the local hospitals' emergency rooms.

After hours, persons in emergent situations, or someone on his/her behalf, may phone the Emergency After-Hours Telephone Response line (1-800-526-5059) or go to their closest hospital emergency room.

Emergency Services may also be requested by personnel at hospital emergency rooms, courts, or jails 24 hours a day.

A screening of the person's condition and a disposition by qualified personnel will occur within three hours of the person being available for the screen. Emergency screenings can be conducted at any of the agency clinics during business hours and at hospitals either during business hours or after hours.

III. Persons or guardians seeking routine (non-emergent) access to services may phone CCMHS Access (906-483-5555 or 1-877-906-CCMH [2264]) during regular business hours and speak to an access worker (mental health professional) who completes a phone screening. If the call is identified as an emergent situation, the call is immediately diverted to the Emergency Services Team at CCMHS.

The CCMHS Access System will also take information from anyone acting on behalf of a person and make arrangements to complete a screening with the person or his/her guardian.

Requests for services may be made in person at any of the CCMHS clinics during regular business hours. Persons who present with immediate risk/emergency situation are referred for assessment by the Emergency Services team.

A person who has been discharged from services, and requests services again within one year, will not have to go through the duplicative screening process. They shall be triaged to determine whether presenting mental health needs are emergent or routine.

Requests for routine services that are made after hours through the Emergency After-Hours Telephone Response line will be routed to the CCMHS Access Unit the next business day.

IV. If a person with Medicaid or Healthy Michigan is determined to be eligible for an initial assessment upon completion of the screening by the CCMHS Access System, the person is scheduled for a face-to-face or televideo assessment with a mental health professional at a CCMHS office within fourteen (14) days. The mental health professional completing the assessment has an active Michigan license and/or certification with a relevant scope of practice.

A. The mental health professional who conducts the assessment:

1. Completes an initial clinical review to obtain information regarding the person's eligibility for Medicaid specialty services and supports, Healthy Michigan or, for those who do not have any of these benefits, as a person whose presenting needs for mental health services make them a priority to be served.

2. Collects information for decision making and reporting purposes.

3. Informs people about all the available mental health and substance abuse services and providers and their due process rights under Medicaid, or Healthy Michigan, and the Michigan Mental Health Code.

4. Approves requests for services or supports that meet criteria.

5. Provides Adverse Benefit Determination and Second Opinion Notice for services if denied due to not meeting eligibility criteria.

6. If the individual is not eligible for services, refers to community resources that may meet their needs.

V. To the extent possible and appropriate, persons seeking services are given a choice of physician or other mental health professional.

VI. Persons making an initial request for services, who after either the initial screening or face-to-face assessment, are determined to be ineligible for services are informed of the decision and of their right to request a second opinion. A notice of denial for an initial assessment or face-to-face assessment is provided by CCMHS. These notices include specific contact information and informal appeal rights. Referral sources, with the consent of the person, are notified of this decision as well. Persons who are determined to be ineligible for services are referred to alternative community resources that may meet their needs.

VII. CCMHS provides outreach to under-served and hard-to-reach populations and is accessible to the community-at-large.

VIII. CCMHS has an established mechanism to periodically seek feedback from people who have had contact with staff members to confirm that those staff members have demonstrated a welcoming, accepting attitude and that they have helped with service requests.

CROSS REFERENCE:

CCMHS Policy – Grievance and Appeal Processes – Medicaid and Healthy Michigan (HM)

CCMHS Policy – Grievance and Appeal Processes – Non-Medicaid

NorthCare Network Access Policy

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: January 25, 2023 Background Checks.P14

RESCINDS: January 19, 2022

CATEGORY: Personnel

SUBJECT: Background Checks

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to employ, contract with, or enter into a relationship with only those individuals or providers that are in good standing with the law and that meet all requirements set by federal and state guidelines and by accrediting authorities. In addition, CCMHS will comply with the MDHHS/PIHP (Master Contract), which requires certain checks to identify excluded and sanctioned parties relating to health care and procurement issues. Independent contractors in bordering states are held to the same standards and procedures for background checks and must meet all applicable licensing and certification requirements of their state.

PURPOSE: The purpose of this policy is to establish a uniform procedure for conducting background checks for all the Board of Directors, employees, and independent contractors who are employed by or contract with CCMHS as well as interns and volunteers who may, from time to time, be affiliated with CCMHS.

DEFINITIONS:

Independent Contractors: Practitioners who are not operating as part of another organizational provider and comply with all federal, state and local laws regarding business permits and licenses of any kind that may be required to carry out the said business and tasks to be performed under said contract.

Interns: Students or recent graduates undergoing supervised practical training.

Volunteers: Persons who enter into transactions without being under any legal obligation to do so and without being promised any remuneration for services.

PROCEDURE:

I. Background checks for potential and current Board of Directors, employees, independent contractors, interns, and volunteers will be as follows if applicable:

   A. State Driver's License Verification – acquire verification from applicable state driver's license department that license is active and in good standing (prior to hire and annually).

   B. State of Michigan – ICHAT (Internet Criminal History Access Tool) www.michigan.gov/ichat - Michigan State Police review of pertinent criminal background investigation (prior to hire and annually).

   C. Michigan Public Sex Offender Registry (PSOR)–www.mipsor.state.mi.us – to verify that the person is not on the registered sex offender website in Michigan.

   D. Offender Tracking Information System (OTIS) –www.state.mi.us/mdoc/asp/otis2.html - to verify that the person is not registered on the criminal offender tracking system in Michigan.

E. National Sex Offender Public Website – www.nsopw.gov – to verify that the person is not on the national registered sex offender website.

F. United States Government – Excluded Parties List – www.sam.gov to verify that the person is not excluded from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits (prior to hire, monthly and with on-going updates).

G. US Department of Health and Human Services –www.oig.hhs.gov/fraud/exclusions.html - to verify that the person is not excluded from participating in Federally-funded health care programs for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans (prior to hire, monthly and on-going updates).

H. State of Michigan Sanctioned Providers List – Department of Health and Human Services– www.michigan.gov/mdhhs to verify that the person is not included on Sanctioned Providers List (prior to hire, monthly and on-going updates).

I. Nurse Aide Registry –https:/registry.prometric.com/registry/ publicMI to verify that the person is not "flagged" on the Michigan Nurse Aide Registry (prior to hire).

J. State of Michigan – Department of Licensing & Regulatory Affairs – www.michigan.gov/lara - to review current disciplinary action reports for the Bureau of Health Care Services.

K. State of Michigan – Department of Health and Human Services – www.michigan.gov/mdhhs - to review current disciplinary action reports for the Bureau of Health Care Services.

L. State of Michigan – Department of Health and Human Services – michigan.gov/healthlicense - to verify professional license for applicable employees (prior to hire and upon renewal of license).

1. Original must be copied by the Human Resources Department and maintained in the personnel file.

M. Long Term Care Background Check - A state and federal fingerprint-based criminal history check which includes verification through available registries (above) that no disqualifying information appears, as well as fingerprinting, for any person who receives an offer of employment in a position that has regular access to a person residing in a licensed adult foster care home operated by CCMHS, or to the person's property, financial information, medical records, treatment information, or any other identifying information.

N. The National Practitioner Databank/Healthcare Integrity and Protection Databank query – www.npdb-hipdb.com, or all of the following must be verified:

1. Minimum five-year history of professional liability claims resulting in a judgment or settlement;
2. Disciplinary status with regulatory board or agency;
3. Medicaid/Medicaid sanctions.

O. As applicable, the Central Registry of the Michigan Department of Health and Human Services – to request a Child Abuse / Neglect Central Registry Check.

II. Criminal background checks are completed prior to hire on all employees; however, employment is conditional on the receipt of the AFC fingerprint response for applicable employees. Information that would prevent a potential employee from performing the functions of the position within federal, state or accrediting authority guidelines will be reviewed by the Human Resources Director and supervisor and the potential employee will not be offered employment.

III. Providers of clinical services must be fully qualified and in good-standing. The Credentialing Program establishes guidelines for prospective providers to follow to meet Agency standards. The credentialing process must be completed prior to offer of employment.

IV. The Human Resources Department will search the following "excluded parties" databases at least monthly to ensure that they do not contain the names of the Director, Board Members, or management employees of CCMHS or providers contracting with CCMHS.

- System for Award Management – https://www.sam.gov – to verify that the person is not excluded according to the official U.S. Government system that consolidated capabilities of several records databases.
- US Department of Health and Human Services - http://exclusions.oig.hhs.gov - to verify that the person is not excluded from participating in federally-funded health care programs because of program-related fraud or patient abuse, licensing board actions or default on Health Education Assistance Loans.
- State of Michigan Sanctioned Providers List – Department of Community Health – www.michigan.gov/medicaidproviders - to verify that the person is not included on the Sanctioned Providers List.

V. CCMHS must search the exclusions databases monthly in order to capture exclusions and reinstatements that have occurred since the last search.

VI. If any of the above background and/or credential checks produces information that would invalidate a current employee from performing the functions of his/her position within federal, state or accrediting authority guidelines, this information will be reviewed by the supervisor and Human Resources Director. A recommendation will be made to the Executive Director as to possible sanctions needed, which may include termination of employment.

VII. CCMHS cannot employ or contract with persons who:

- Are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department;
- Have been convicted of a felony;
- Have a criminal conviction for program related fraud, patient abuse, licensing board actions or default on a Health Education Assistance loans.

VIII. Individuals who appear on any of the "excluded parties" lists cannot have an employment, consulting, or other arrangement with CCMHS for the provision of items or services that are significant and material to CCMHS's obligations under its contract with the State. Further, certain criminal offenses which may exclude CCMHS from participation in the Medicare or State Health Care Programs must be reported to the NorthCare Network promptly. These offenses are described in 42 CFR 1001.1001(a) (1) and Section 1128(a) and (b) of the Social Security Act.

IX. CCMHS must notify the NorthCare Network (who in turn must notify the Michigan Department of Health and Human Services) immediately if search results indicate that any individuals with ownership or control interests (i.e., the Director, Board Members, and management employees) in CCMHS are on any of the exclusions databases.

CROSS REFERENCE:
CCMHS Policy – Credentialing Program
CCMHS Policy – Employment - Selection Process

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY & PROCEDURE

DATE: September 25, 2024 Behavior Treatment Committee.P11

RESCINDS: June 26, 2024

CATEGORY: Recipient Rights

SUBJECT: Behavior Treatment Committee

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that any restrictive or intrusive program elements of any Individual Plan of Service (IPOS) be used only as a last resort and when absolutely necessary to protect the health and safety of the person and others when people exhibit seriously aggressive, self-injurious or other challenging behaviors that place the person or others at imminent risk of physical harm. Any plan that proposes restrictive or intrusive treatment techniques, including psychoactive medication for the purposes of behavior control, and the use of protective devices, must be reviewed and approved by the Agency's Behavior Treatment Committee (BTC). Aversive techniques and seclusion, as defined below, are prohibited.

PURPOSE: To establish standards and guidelines for the professional review, approval or disapproval and monitoring of plans that proposes the use of intrusive or restrictive program elements or the use of psychoactive medication for behavior control.

DEFINITIONS:

Aversive Techniques: Techniques that are punishing, physically painful, emotionally frightening, deprivational, or put a person at medical risk when they are used; or any technique that requires the deliberate infliction of unpleasant stimulation (stimuli which would be unpleasant to the average person or that would have a specific unpleasant effect on a particular person) to achieve management, control or extinction of seriously aggressive, self-injurious or other behavior that places the person or others at risk of physical harm. Examples of such techniques include use of mouthwash, water mist or other noxious substance to consequate behavior or to accomplish a negative association with a target behavior, and use of nausea-generating medication to establish a negative association with a target behavior or for directly consequating a target behavior. The *voluntary* use by the person of an intervention such as antabuse for alcoholism, for example, is not considered an aversive technique for purposes of this policy. Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (such as exposure therapy for anxiety) are not considered aversive for purposes of this policy. **USE OF AVERSIVE TECHNIQUES IS PROHIBITED**.

Consent: A written agreement signed by the person, the parent of a minor, or a person's legal representative with authority to execute consent, or a verbal agreement of a person that is witnessed and documented by someone other than the service provider.

Functional Behavioral Assessment (FBA): An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an effective and efficient behavior plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain or end a behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the

function of a behavior, rather than just focusing on the behavior itself so that a new behavior or skill will be substituted to provide the same function or meet the identified need. Functional assessments should also identify situations and events that precede positive behavior to provide more information for a positive behavior support plan.

Emergency Interventions: There are only two emergency interventions approved by Michigan Department of Health and Human Services(MDHHS) for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.

Imminent Risk: An event/action that is about to occur that will likely result in the potential harm to self or others.

Intrusive Techniques: Techniques that encroach upon the bodily integrity or the personal space of the person to achieve treatment, management, control or extinction of a seriously aggressive, self-injurious or other behavior that places the person or others at risk of physical harm. An example is the use of direct observation procedures during times that would otherwise be considered private by an average person; or use of a medication or drug that is not a standard treatment or dosage for the person's condition. Use of intrusive techniques as defined here requires **REVIEW AND APPROVAL** by the Behavior Treatment Committee.

Physical Management: An agency-approved technique used by trained employees as an emergency intervention to restrict the movement of a person by continued direct physical contact in spite of the person's resistance in order to prevent the person from physically harming himself, herself, or others.

Physical management shall only be used on an emergency basis when the person or the situation is presenting an imminent risk of serious physical harm to himself/herself or others. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection, or holding his/her hand. Physical management shall not be included as a component in a behavior treatment plan.

Prone Immobilization: Extended physical management of a person in a prone (face down) position, usually on the floor, where force is applied to his or body in a manner that prevents him or her from moving out of the prone position. **PRONE IMMOBILIZATION OF A PERSON OR ANY PHYSICAL MANAGEMENT THAT RESTRICTS A PERSON'S RESPIRATORY PROCESS, FOR THE PURPOSE OF BEHAVIOR CONTROL, IS PROHIBITED UNDER ANY CIRCUMSTANCES.**

Positive Behavior Support: A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other behaviors that place the person or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance qualify of life and reduce behaviors such as self-injury, aggression, property destruction, and pica. Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.

Request For Law Enforcement Intervention: Calling 911 and requesting law enforcement assistance as a result of a person exhibiting seriously aggressive, self-injurious or other behavior that places the person or others at risk of physical harm. Law enforcement should be called for assistance **ONLY WHEN: CAREGIVERS ARE UNABLE TO REMOVE OTHER PEOPLE FROM THE HAZARDOUS SITUATION TO ASSURE THEIR SAFETY AND PROTECTION, SAFE IMPLEMENTATION OF PHYSICAL MANAGEMENT IS IMPRACTICAL, AND/OR APPROVED PHYSICAL MANAGEMENT TECHNIQUES HAVE BEEN ATTEMPTED BUT HAVE BEEN UNSUCCESSFUL IN REDUCING OR ELIMINATING THE IMMINENT RISK OF HARM TO THE PERSON OR OTHERS.**

Restraint: The use of a physical or mechanical device to restrict a person's movement; specifically, anything that immobilizes or reduces the ability of the person to move his/her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the person or others at risk of physical harm. Restraint does not include the use of a device primarily intended to provide anatomical or physical support that is ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving a person's physical functioning; or safety devices required by law, such as car seat belts or child car seats used in vehicles. **THE USE OF PHYSICAL OR MECHANICAL DEVICES USED AS RESTRAINT IS PROHIBITED IN ALL AGENCY PROGRAMS UNDER ANY CIRCUMSTANCES.**

This definition excludes the following:

Anatomical Or Physical Support: Body positioning or a physical support ordered by a physician, physical or occupational therapist for the purpose of maintaining or improving a person's physical functioning.

Protective Device: A device or physical barrier to prevent the person from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined here shall not be considered a "restraint" as defined above. However, it must be incorporated in the IPOS through a behavior treatment plan which has been reviewed and approved by the BTC and received special consent from the person or his/her legal representative.

Medical Restraint: The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the person quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the IPOS for medical or dental procedures.

Safety Devices Required By Law: such as car seat belts or child car seats used while riding in vehicles.

Restrictive Techniques: Those techniques which, when implemented, will result in the limitation of the person's rights as specified in the Mental Health Code and the federal Balanced Budget Act. These techniques are used for the purposes of management, control or extinction of seriously aggressive, self-injurious or other behaviors that place the person or others at risk of physical harm. Restrictive techniques include the use of a psycho-active medication for the purpose of behavior control. Any use of psycho-active medication prescribed for persons with a primary diagnosis of an intellectual/developmental disability and an existing secondary mental illness diagnosis must conform to accepted standards of practice for that specific diagnosis. Use of restrictive techniques as defined here requires **REVIEW AND APPROVAL** by the Behavior Treatment Committee.

Seclusion: The placement of a person in a room, alone, when freedom to leave the segregated room or area is prevented by any means. **SECLUSION IS PROHIBITED IN ANY AGENCY PROGRAM UNDER ANY CIRCUMSTANCES.**

Special Consent: The written consent of the person, the legal guardian, the parent with legal custody of a minor child or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise violate the person's rights. The general consent to the Individual Plan of Service is not sufficient to authorize implementation of a behavior treatment plan that includes intrusive and/or restrictive techniques. Implementation of a behavior treatment plan without the special consent of the person, guardian or parent of a minor may ONLY occur when the person has been adjudicated pursuant to the provision of one or more of the following sections of the Mental Health Code:

-469a Treatment program as alternative to hospitalization, court order;

-472a Initial, second or continuing order for involuntary mental health treatment, duration of order hearing;

-473 Petition for second or continuing order of involuntary mental health treatment, contents, clinical certificate;

-515 Criteria for judicial admission;

-518 Findings, disposition of the court regarding judicial admission;

-519 Alternative care and treatment.

PROCEDURE:

I. CCMHS shall have an established Behavior Treatment Committee (BTC) that is responsible for the review and approval or disapproval of all behavior treatment plans that propose the use of restrictive or intrusive interventions. If CCMHS delegates the functions of the Committee to a contracted mental health service provider, CCMHS will monitor that Committee to assure compliance with this policy.

II. Behavior Treatment Committee Membership:

A. This specially constituted body shall be comprised of at least three people, two of whom meet the following criteria:

- a board-certified behavior analyst (BCBA) or licensed behavior analyst, or a full limited licensed, or temporary limited licensed psychologist with formal training and experience in applied behavior analysis.
- a licensed physician or psychiatrist.

B. A representative of the Office of Recipient Rights shall participate on the BTC as an ex-officio, non-voting member in order to provide consultation and technical assistance to the BTC.

C. At least one of the BTC members shall not be the developer or implementer of the behavior treatment plan.

D. Other non-voting members may be added at the Committee's discretion and with the consent of the person whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

E. The chairperson and members of the BTC are appointed by the Executive Director for a term of not more than two years. Members may be re-appointed to consecutive terms.

F. The psychologist/BCBA or physician must be present during the review and approval process.

III. Behavior Treatment Committee Functions:

A. Review and Approval or Disapproval of Proposed Plans:

1. The BTC shall expeditiously review all program plans that involve the use of restrictive or intrusive program elements as defined above. Approval (or disapproval) of proposed program plans shall be done in light of current peer-reviewed psychological/psychiatric literature or practice guidelines and according to the "Behavioral Treatment Plan Standards" listed in Paragraph IV.

2. Any behavior treatment plan that proposes to use seclusion, restraint, physical management in a non-emergent situation or aversive techniques as defined above shall not be approved by the BTC.

3. Expedited reviews of proposed behavior treatment plans will be completed in emergent situations, according to the Agency's "Emergency BTC Approval" Procedure. Expedited plan reviews may be requested when the plan requires immediate implementation. Every attempt will be made to review and approve the plan within 48 hours of the request.

B. Each plan shall be reviewed and approved or disapproved as expeditiously as possible.

C. Any Behavior Treatment Committee member who has prepared a behavior treatment plan to be reviewed must excuse him/herself from the final decision-making.

D. When plans are approved, the BTC shall establish the frequency at which it will review the plan's implementation. Plan reviews shall indicate the specific restrictive plan elements being utilized and note any progress or problems associated with the implementation of the approved plan. Any medication changes since the time of plan approval or last review shall be duly noted. Progress will be noted with the intent of replacing restrictive program procedures with more positive treatment strategies as progress is realized. The BTC shall also offer consultation to providers and plan authors when there is a lack of progress or problems associated with the implementation of the plan. Ongoing approval of the plan must be based on a continued risk/benefit analysis of the behaviors present and consider the health and safety needs of the person that either support or contraindicate continued implementation. Plan approvals and reviews must be signed by the BTC members present, including at least the required members as noted under Paragraph II.

1. A review of each plan with intrusive or restrictive techniques shall occur no less than quarterly; or more frequently if clinically indicated. In addition, the person, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan (MCL330.1712[2].

2. The entire behavior treatment plan should be reviewed by the Behavior Treatment Committee based on the intensity of the intrusive or restrictive interventions and the frequency with which they are applied.

    a. The Behavior Treatment Committee's approval and review of the plan will be documented in the person's clinical record.

E. When plans are not approved, alternatives or recommendations should be offered.

F. The BTC will meet as often as necessary, but no less than quarterly, and on an emergency basis as needed to ensure that appropriate and timely approval/disapproval and reviews of all proposed plans are completed.

G. The BTC shall keep minutes of each meeting to clearly delineate its actions.

H. The BTC will track and analyze incidents of the use of emergency physical management and/or law enforcement involvement for behavior emergencies and the use of intrusive and restrictive techniques at every meeting. These reviews will include:

1. Dates and numbers of interventions used;
2. The settings (e.g., home or work) where behaviors and interventions occurred;
3. The incident report coding of the event;
4. Observations about any events, settings, or factors that may have triggered the behavior;
5. Behaviors that initiated the techniques;

6. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention;
7. Description of positive behavioral supports used;
8. Behaviors that resulted in termination of the interventions;
9. Length of time of each intervention;
10. Staff development and training and supervisory guidance to reduce the use of these interventions;
11. Review and modification or development, if needed, of the person's behavior plan.

b. If there is a continued pattern of physical management to manage challenging behaviors, the BTC is responsible to initiate quality improvement efforts. Should use occur more than three (3) times within a thirty (30) day period for a person, the IPOS must be revisited through the person-centered planning process and modified if needed.

I. The BTC Chair or designee will report required information to the Quality Improvement Committee for review and analysis quarterly. Information will include information related to the use of physical management, use of law enforcement, and any injuries or death as a result of either of those interventions. The Qualify Improvement Committee will evaluate any trends and make recommendations for further agency action.

J. CCMHS will appoint a representative to the NorthCare Network Clinical Practice Quality Improvement Committee and provide any information requested or required by NorthCare.

K. At least every other year, the BTC will evaluate the effectiveness of the behavior plans by surveying stakeholders including the guardians, family members and staff.

IV. Behavior Treatment Plan Standards:

A. Any plan that involves only positive reinforcement and/or non-coercive teaching procedures are considered non-restrictive and do not need approval through the BTC process.

B. Any behavior treatment plan with restrictive or intrusive elements shall be:

1. developed through the person-centered planning process that involves the person, their family members, and/or legal guardian or representative;
2. clearly documented in the plan of service;
3. developed with the least restrictive interventions available to ensure the health and safety of both the person and others in their environment;
4. time limited;
5. approved by the Behavior Treatment Committee prior to implementation.

C. Prior to approval, the Behavior Treatment Committee must be provided with:

1. results of assessments and evaluations to rule out physical, medical and environmental causes that might be the cause of the challenging behaviors;
2. a functional behavior assessment;
3. results of inquiries about any medical, psychological or other factors that might put the person subjected to intrusive or restrictive techniques at high risk of death, injury or trauma;

4. evidence that positive behavioral supports and interventions, including their amount, scope and duration, to change the behavior have been attempted and proved to be unsuccessful; or there is other sufficient clinical assessment and opinion to use the intervention in order to reduce risk of death, injury or trauma to the person and/or others;
5. a plan to identify continued efforts to find other options;
6. a plan for monitoring the treatment plan;
7. a plan for employee training to assure consistent implementation and documentation of the intervention(s).

D. Behavior Treatment Committee approval must occur prior to the implementation of the proposed plan.

E. Prior written special consent, as defined above, must be given by the person, or his/her guardian if one has been appointed, or the parent with legal custody of a minor before the plan can be approved by the Behavior Treatment Committee.

Consent from the person served should be attempted to be attained in all situations, but is not essential if a legal representative provides consent. If a consent from the person served is not able to be obtained, a rationale will be written on the consent to indicate the lack of signature. A written consent should be obtained as soon as possible if a verbal is obtained.

CROSS REFERENCE:

CCMHS Policy - Management of Behavioral Emergency

CCMHS Policy – PRN Medications

CCMHS Policy – Informed Consent to Psychotropic Chemotherapy

CCMHS Policy – Report, Investigation, and Review of Unusual Incidents

NorthCare Network Behavior Treatment Review Policy

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: April 27, 2016 Choice of Mental Health Professional.P2

RESCINDS: July 25, 2012

CATEGORY: Recipient Rights

SUBJECT: Choice of Mental Health Professional

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to provide people receiving services with the choice of Mental Health Professional within the limits of available staff in the program from which services are being provided.

PURPOSE: The purpose of this policy is to ensure that people receiving service are provided with the choice of Mental Health Professional within the limits of available staff.

DEFINITIONS:

Mental Health Professional: An individual who is trained and experienced in the area of mental illness or intellectual/developmental disabilities and who is one of the following:

1. A physician who is licensed to practice medicine or osteopathic medicine and surgery in this state under part 170 of the public health code, 1978 PA 368 MCL 333.17001 to 333.17084, or to engage in the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

   A. "Psychiatrist" means one or more of the following:

      i. A physician who has completed a residency program in psychiatry approved by the accreditation council for graduate medical education or the American osteopathic association, or who has completed 12 months of psychiatric rotation and is enrolled in an approved residency program as described in this subsection.

      ii. A psychiatrist employed by or under contract with the department or a community mental health services program on March 28, 1996.

      iii. A physician who devotes a substantial portion of his or her time to the practice of psychiatry and is approved by the director.

2. A psychologist licensed to practice in this state under part 182 of the public health code, 1978 PA 368, MCL 333.18201 to 333.18237, and who devotes a substantial portion of his or her time to the diagnosis and treatment of individuals with serious mental illness, serious emotional disturbance, substance use disorder, or intellectual/developmental disability.

3. A registered professional nurse licensed to practice in this state under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242)

4. A licensed master's social worker licensed under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518)

5. A licensed professional counselor licensed to practice in this state under article part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177)

6. A marriage and family therapist licensed under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915).

PROCEDURE:

I. General Requirements

A. A person receiving services who is granted a change in Mental Health Professional will be encouraged to work with the new Mental Health Professional for a minimum of six months or 6 sessions whichever is greater prior to making another request for change, unless it is the opinion of the professional that a change would be advantageous to the person.

II. Request for a change of Mental Health Professional

A. A request for change in Mental Health Professional may be made by the person to his/her current Mental Health Professional, to the Program Supervisor or through the Customer Services Department.

B. The Program Supervisor will be informed of the request.

C. The Program Supervisor shall review the request and determine if a change would be clinically advantageous to the person and if another qualified staff is available to provide the service. If so, the Program Director will assign the person a new Mental Health Professional.

D. If the change would not be clinically advantageous, or if another Mental Health Professional is not available in the program, the person requesting the change will be informed.

CROSS REFERENCE:

Mental Health Code–Sections 100b(14), 100c(10), & 713

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: June 28, 2017 Clinical Privileging of Individual Practitioners.P6

RESCINDS: June 29, 2016

CATEGORY: Contracts and Credentialing

SUBJECT: Clinical Privileging of Individual Practitioners

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that clinical treatment and support services are provided only by qualified and competent practitioners within the scope of their licenses and clinical privileges. CCMHS requires all professional practitioners who are employed by or provide services through an independent contract with CCMHS to have a documented review and approval of their clinical privileges. Independent contractors in bordering states are held to the same standards and procedures for clinical privileging and meet all applicable licensing and certification requirements of their state.

PURPOSE: The purpose of this policy is to assure that providers of clinical services are properly privileged to perform the assignments detailed in their job descriptions. The privileging process authorizes the specific scope and content of clinical services that each individual practitioner may perform; and ensures that the practitioner is operating within their scope of practice and engaging in clinical activities that they are qualified to perform. Privileging must be granted according to the primary eligibility groups being served.

DEFINITIONS:

Independent Contractors: Practitioners who are not operating as part of another organizational provider and comply with all federal, state and local laws regarding business permits and licenses of any kind that may be required to carry out the said business and tasks to be performed under said contract.

Privileging: The process of determining a health care professional's current skill and competence to perform specific diagnostic or therapeutic procedures that the professional requests to perform as a participant in or an affiliate of a healthcare facility or system. The result of privileging is that a practitioner is permitted by a healthcare organization or network to conduct those specific procedures. (American Managed Behavioral Healthcare Association)

Senior Clinical Staff Person: A senior clinical staff person who has current, unrestricted clinical licenses(s); qualifications to perform clinical oversight for the services provided; post-graduate experience in direct patient care; and Board certification (if the senior clinical staff person is an M.D. or D.O.).

PROCEDURE:

I. Initial Privileges – Initial privileging must be done at the time of hire or initiation of the contract for services.

   A. The supervisor completes the NorthCare Clinical Privileging Form and submits it to the Human Resources Department.

   B. The supervisor is responsible for ensuring that each practitioner, directly or contractually employed, meets all applicable licensing, scope of practice, contractual and Medicaid Provider Manual requirements to provide the service.

C. The Human Resources Department reviews the application for completeness and submits it to the Credentialing Committee.

II. Temporary Privileges

A. Temporary privileges may be granted at time of hire or contract initiation, at a time of change in clinical privileges, and/or when a need for temporary privileging is identified.

B. A decision regarding temporary privileges will be made within thirty-one (31) calendar days of receipt of the completed form.

C. Temporary privileges may be granted for a term of up to one (1) year.

III. Re-Privileging

A. In order to renew privileges for the coming year, the supervisor will review the practitioner's licensing, certification and training requirements at the time of the annual performance review. A new NorthCare Clinical Privileging Form will be completed to renew existing privileges and/or make appropriate changes. Privileging status (whether changes have been made to privileging or not) will also be noted on the Performance Review form.

B. Re-privileging must also be done any time a practitioner's duties/responsibilities change in terms of the primary eligibility group with whom the practitioner works, and/or the scope of practice.

C. The process for re-privileging is the same as for initial privileging.

IV. The Credentialing Committee:

A. Delegates the authority to approve or disapprove temporary, initial or on-going privileges to the Senior Clinical Staff Person if the NorthCare Clinical Privileging Form is complete and all support documentation is provided.

B. Reviews the applications presented by the Senior Clinical Staff Person at the next scheduled meeting or at a specially scheduled meeting if necessary. The Committee may conduct a personal interview with the applicant, if desired.

C. The Credentialing Committee gives final approval for temporary, initial or on-going privileges, disapproves all or some privileges, or returns the application to the applicant for further information.

D. If the decision is adverse, the applicant will be provided with the reasons for the decision in writing. The applicant then has access to the Appeals Process.

V. Appeals Process

A. If an organizational provider or individually licensed practitioner disagrees with a determination by CCMHS in the application process or during review of a practitioner's status, and wishes to have the matter reviewed at a higher level:

1. The practitioner may submit a written request and supporting documentation to CCMHS's CEO or designee within thirty (30) calendar days of disposition. The request must include the reason for the appeal and the documentation to support the appeal.

2. An appeal review will be conducted within twenty (20) calendar days of receipt of the practitioner's request by a panel of at least three qualified individuals not involved in previous decisions relating to this appeal. At least one member will be a participating provider who is not involved in the day-to-day operations of network management and who is a clinical peer of the participating provider that filed the dispute.

3. After formal review of the dispute, a written summary of the outcome will be given to the practitioner, within fourteen (14) calendar days of completion.

4. The decision of the appeal review panel will be the final decision regarding the dispute.

5. In the event of an emergent non-compliance dispute, the appeal process will be initiated and completed within five (5) working days.

VI. Final Approval

A. NorthCare Network holds final approval authority for the clinical privileging granted by CCMHS.

CROSS REFERENCE:

CCMHS Policy – Credentialing Program

CCMHS Policy – Contracting for Clinical Services

MDCH/PIHP Master contract (Medicaid Managed Specialty Supports and Services Concurrent 1915(B)(c) Waiver Program), Attachment P6.4.3.1

NorthCare Network – Credentialing-Privileging Policy

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: May 25, 2022 Code of Ethics.P5

RESCINDS: May 26, 2021

CATEGORY: Board Administration

SUBJECT: Code of Ethics

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) to conduct its operations in accord with the public trust vested in it by the citizens of the state, and to conduct its operations in accordance with the CCMHS Code of Ethics.

PURPOSE: The Code of Ethics is applied to all aspects of the Board's services and operations including conduct and personal behaviors, clinical and business practices, and all aspects of the governance of the Board. This policy identifies how the Code of Ethics is communicated to personnel, persons served and other stakeholders. It addresses the Agency's method of response to allegations of violations of the Code.

PROCEDURE:

I. Communication:

A. The orientation of all personnel includes the Code of Ethics and its application. All personnel receive a copy of the Code of Ethics. Documentation is required.

B. The Code of Ethics is reviewed annually with all personnel. This may be accomplished in program staff meetings or in multi-purpose trainings. Documentation is required.

C. Consumers receive a copy of the Code of Ethics in brochure format during orientation to services.

D. A summary of the Code of Ethics is posted in each of the Centers: Rice Memorial Center – Houghton; CLK Center – Calumet; Baraga County Center – L'Anse; and Ontonagon Center – Ontonagon.

E. The Code of Ethics is posted on the agency website.

F. The Code of Ethics will be provided to stakeholders with the Stakeholder Survey Response.

II. Response to allegations of violation of the Code of Ethics:

A. All alleged violations are addressed following the Responsibilities for Reporting Non-Compliance policy and the Corporate Compliance Plan.

III. Employees are protected by the Michigan Whistleblower's Protection Act.

CROSS REFERENCE:

CCMHS Policy – Recipient Rights Complaints/Appeals

CCMHS Policy – Responsibilities for Reporting Non-Compliance

CCMHS Policy – Corporate Compliance Plan

Michigan Whistleblower's Protection Act 469 of 1980

ATTACHMENT:

Code of Ethics

Attachment

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD

CODE OF ETHICS

PREAMBLE

This code is intended to provide both general and specific principles to cover most situations encountered by Copper Country Mental Health Services Board Staff. At the core of this code is our belief in accountability, and it is based on core values of:

- *Accountability to the public*
- *Choice*
- *Efficiency*
- *Empowerment*
- *Prudent use of resources*
- *Respect for the life, value and dignity of individuals*
- *Avoiding conflict of interest*
- *Effectiveness*
- *Empathy*
- *Inclusion*
- *Security*
- *Being fair and impartial*

GENERAL PRINCIPLES

Competence

- *We strive to maintain high standards of conduct in our work.*
- *We recognize the boundaries of our expertise.*
- *We recognize the need for ongoing education.*

Concern for Other's Welfare

- *We promote a safe and comfortable environment.*
- *We promote informed choice.*
- *We do not exploit professional relationships.*

Respect

- *We respect the dignity and worth of all people.*
- *We promote the right to privacy and autonomy.*
- *We respect cultural differences and diversity.*

Social Responsibility

- *We work to reduce social stigma.*
- *We encourage policy that promotes the interests of the people we serve and the public.*
- *We comply with the law.*

Integrity

- *We strive to be honest, fair and respectful of others.*
- *We attempt to clarify our roles and responsibilities.*
- *We avoid conflict of interest.*

Professional Conduct

- *We uphold the values, ethics and mission of the Agency.*
- *We adapt to meet the needs of people from different backgrounds.*
- *We collaborate with others to promote consumer interests.*

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
CODE OF ETHICS

SPECIFIC PRINCIPLES

Business

- *We bill appropriately for services delivered.*
- *We conduct business in accordance with Agency values and general ethics principles.*
- *We protect against the misuse of funds.*
- *We award contracts via approved selection processes.*
- *We ensure employees, and clinical and non-clinical contractors are not excluded from Federal or State Health Care Programs.*

Human Resources

- *We follow all laws prohibiting discrimination.*
- *We are committed to providing an environment free of harassment.*
- *We show appreciation to employees.*
- *We apply fair and equitable treatment to all employees.*
- *We respect the employee's right to privacy.*

Marketing

- *We compete for business on merit alone and do not engage in attempts to discredit competitors.*
- *We share testimonials that are truthful.*
- *We provide information able to be read and understood by current and potential consumers.*

Service Delivery

- *We provide services that are consumer directed.*
- *We strive to provide quality services.*

Professional Responsibilities

- *We follow a Code of Ethics for our respective professional disciplines.*
- *We follow the Michigan Mental Health Code.*
- *We comply with all statutes, regulations and guidelines applicable to Federal and State Health Care Programs.*

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: April 24, 2019 Communication. Telephone, & Visiting Rights.P4

RESCINDS: April 27, 2016

CATEGORY: Recipient Rights

SUBJECT: Communication, Telephone, and Visiting Rights

POLICY: It is the policy of Copper Country Mental Health Services (CCMHS) Board to protect recipient's rights to unimpeded communication with others by telephone and mail, and to have visitors he or she chooses, unless limited for an individual recipient in the plan of service.

PURPOSE: The purpose of this procedure is to ensure that a recipient's personal privacy is assured and that communication, telephone and visiting rights are not limited without justification, authorization, and proper notification.

PROCEDURE:

I. All limitations of Communication, Telephone and Visiting Rights must meet the requirements of the Home and Community Based Services Final Rule (HCBS), the Mental Health Code, and be approved by the Behavior Treatment Committee (BTC). Please see Section V.

II. Communication with Others by Telephone and Mail

A. A recipient shall place and receive telephone calls and talk on the telephone with privacy.

1. If a recipient is indigent, he/she will be provided with reasonable access to the telephone for long-distance calls. Otherwise, the expense of long-distance calls is the recipient's responsibility.

B. A recipient shall receive and send mail without anyone else opening it.

C. Assistance must be provided to individuals who require help in opening, reading, and sending mail.

D. Non-letterhead stationary, envelopes, pens or pencils and postage in reasonable amounts are available and provided to residents on request who are unable to procure such items.

E. If a limitation is in place requiring a staff to open a recipient’s incoming mail or if a limitation is in place requiring a staff to open suspected contraband that is documented in the plan of service, the recipient and another staff member shall be present. Instances of opening or destruction of mail by staff is documented in the clinical record.

F. Incoming mail shall be distributed promptly.

G. Each residence will provide for daily pick up and deposit of mail.

H. A recipient's outgoing mail shall go unimpeded and shall not be opened or destroyed, unless a limitation is in place requiring a staff to do so.

III. Visitors and Communication with Family or Friends

A. A recipient shall have visitors he or she chooses.

1. The group home shall have arrangements available to provide privacy for families, etc., when visiting the individuals unless such privacy is limited.

2. Visitors need not give prior notice before visiting. However, calling ahead is recommended to be sure that the recipient is planning to be home.

B. The Agency must promote communication and visits with parents, guardians and friends.

1. Participation of parents (if the recipient is a minor) and legal guardians in the process of providing active treatment to a recipient will be promoted by the client service manager unless their participation is unobtainable, restricted by a Court or limited in the recipient's plan of service.

2. Communications from recipients' families and friends will be answered promptly, with consent of the guardian and/or recipient, by group home staff or the client service manager.

3. Parents or guardians will be encouraged to visit any area or programs that provide direct recipient care, as long as such visits do not interfere with the privacy of recipients.

4. Frequent and informal visits, trips or vacations with family, with consent from the guardian and recipient, shall be encouraged.

a) a recipient desiring a leave of absence shall be assisted by the client service manager and home staff as necessary to make arrangements for the leave. (Please see policy on Freedom of Movement.)

5. The parents or guardian shall be promptly notified of any significant incidents, or changes in the recipient's condition including, but not limited to, serious illness accident, death, abuse or unauthorized absence by the Executive Director or her/his Designee.

IV. Communication in any form with a private physician, mental health professional, a court, recipient's attorney, or other person when communication involves matters which are or may be subject of a legal inquiry, i.e., any matter concerning civil, criminal, or administrative law, shall not be limited.

V. As required by the HCBS Final Rule and Mental Health Code, any effort to limit communication by telephone, mail, with visitors, or leave of absences must be:

A. justified by a specific and individualized assessed health or safety need;

B. the minimum limitation necessary to address the need;

C. addressed through the PCP process;

D. determined with the participation of the recipient and the recipient's family, if at all possible;

E. fully explained to the recipient and the recipient's family by the client service manager before implementing the restriction or limitation;

F. approved by the Behavior Treatment Committee;

G. removed when the circumstance that justified its adoption ceases to exist; and is

H. subject to appeal by the resident or another person on the resident's behalf by filing a Recipient Rights complaint.

VI. The following requirements must be documented in the IPOS when a specific health or safety need warrants such a limitation:

A. The specific and individualized assessed health or safety need.

B. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs.

C. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.

D. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.

E. A regular collection and review of data to measure the ongoing effectiveness of the modification.

F. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated

G. The date of expiration.

H. Special consent of the person to the proposed modification.

I. Assurance that the modification itself will not cause harm to the person.

APPLICATION: Residential and Day Programs.

CROSS REFERENCE:

CCMHS Policy - Behavior Treatment Committee

CCMHS Policy - Freedom of Movement

MDHHS Technical Requirement for Behavioral Treatment Plan Review Committees

Home and Community Based Services Final Rule

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: June 28, 2017 Confidentiality.P6

RESINDS: May 27, 2015

CATEGORY: Protected Health Information (PHI)

SUBJECT: Confidentiality

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that all personnel must preserve the integrity and the confidentiality of the protected health information (PHI) of all recipients of services.

PURPOSE: The purpose of this policy is to ensure that the right to confidentiality of Protected Health Information (PHI) is provided to all persons served in a manner consistent with the Michigan Mental Health Code, Michigan Department of Health and Human Services (MDHHS) Administrative Rules, and the Health Insurance Portability and Accountability Act (HIPAA).

DEFINITIONS:

I. **Individually Identifiable Health Information:** is information that is a subset of health information, including demographic information collected from an individual, and:

A. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and;

B. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

1. That identifies the individual; or
2. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

II. **Protected Health Information (PHI):** means individually identifiable health information:

A. Except as provided in paragraph (2) of this definition, that is:

1. Transmitted by electronic media;
2. Maintained in electronic media; or
3. Transmitted or maintained in any other form or medium.

B. Protected health information excludes individually identifiable health information in:

1. Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;

2. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
3. Employment records held by a covered entity in its role as employer.

PROCEDURE:

I. As required by MDHHS Administrative Rule 7051 a summary of Section 748 of the Michigan Mental Health Code is made a part of each recipient file.

II. CCMHS personnel will not use or supply PHI for non-health care uses, such as direct marketing, employment, or credit evaluation purposes.

III. CCMHS personnel will collect and use PHI only for the purposes of providing services and for supporting the delivery, payment, integrity, and quality of those services as follows:

A. To provide proper diagnosis and treatment.

B. With the individual's knowledge and consent.

C. To receive reimbursement for services provided.

D. For research and similar purposes designed to improve the quality and to reduce the cost of health care.

E. As a basis for required reporting of health information.

IV. CCMHS personnel will recognize that PHI collected about recipients must be accurate, timely, complete, and available when needed and shall:

A. Use their best efforts to ensure the accuracy, timeliness, and completeness of data to ensure that authorized personnel can access it when needed.

B. Complete and authenticate records in accordance with the law, medical ethics, and accreditation standards.

C. Maintain records for the retention periods required by law and professional standards.

D. Not alter or destroy an entry in a record, but rather desig-nate it as an error while leaving the original entry intact and create and maintain a new entry showing the correct data.

E. Implement reasonable measures to protect the integrity of all data maintained about recipients.

V. CCMHS personnel will recognize that recipients have a right of privacy and will respect recipients' individual dignity at all times.

VI. CCMHS personnel will act as responsible information stewards and treat **all** PHI as sensitive and confidential and shall:

A. Treat all PHI as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

B. Not divulge PHI unless the recipient, or his/her authorized representative has properly consented to the release or the release is otherwise authorized by law.

C. When releasing PHI, take appropriate steps to prevent unauthorized re-disclosures.

D. Implement reasonable measures to protect the confidentiality of PHI maintained about recipients.

E. Not disclose PHI except as necessary for billing or other authorized purposes as authorized by law and professional standards.

VII. CCMHS personnel will recognize that some medical information is particularly sensitive, such as HIV/AIDS information and alcohol and drug abuse information and will treat such information with additional confidentiality protections as required by law, professional ethics, and accreditation requirements.

VIII. CCMHS personnel will recognize that, although CCMHS "owns" the record, the recipient has a right of access to information contained in the record.

IX. All CCMHS personnel **must** adhere to this policy. CCMHS will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with CCMHS's PHI sanction procedure and personnel rules and regulations.

CROSS REFERENCE:

CCMHS Policy – Service Records System

CCMHS Policy - Use and Release of Protected Health Information

CCMHS Policy – The Minimum Necessary PHI To Be Used, Released, or Requested

Michigan Mental Health Code - Section 748

MDHHS Administrative Rules - Section R 330.7051 Rule 7051.

CFR 45 Parts 160 and 164

APPENDIX 1

SUBJECT: Update To Confidentiality Policy To Include 42cfr Part 2 Compliance

PRIVACY POLICIES AND PROCEDURES AFFECTED:

- Confidentiality Policy and Procedure
- The Minimum Necessary Protected Health Information To Be Used, Released or Requested Policy and Procedure
- Duty to Warn Policy and Procedure
- Abuse and Neglect Policy and Procedure
- Emergency Medical Treatment – CCMH Residential Group Home Residents
- Emergency Medical Treatment – Independent Living Settings
- Notice of Privacy Practices Procedure – Appendix 1 to Use and Release of Protected Health Information Policy and Procedure
- Authorization for Use and Release of PHI Procedure – Appendix 3 to Use and Release of Protected Health Information Policy and Procedure
- Court Order or Subpoena of a Court or Administrative Tribunal Procedure – Appendix 6 to Use and Release of Protected Health Information Policy and Procedure
- Disclosures to Protection and Advocacy Procedure – Appendix 7 to Use and Release of Protected Health Information Policy and Procedure
- Business Partner/Associate Agreement Procedure – Appendix 13 to Use and Release of Protected Health Information Policy and Procedure

PURPOSE: To delineate the exceptions to the CCMHS's policies and procedures as listed above for recipients who are identified as having co-occurring disorders.

DEFINITIONS:

Consumer with Co-Occurring Disorders: A recipient who is diagnosed with a serious mental illness and/or an intellectual/developmental disability and a substance abuse disorder is designated in the demographic reporting data on disabilities as either severely mentally ill or intellectual/developmentally disabled and substance abuse regardless of whether the substance abuse disorder is in remission or a focus of current treatment. The entire chart of the recipient shall be protected by the rules in 42CFR Part 2.

Integrated Treatment Program: An integrated treatment program is defined as those services for recipients with co-occurring disorders and their service providers. The individual IPOS will establish the treatment team for the individual and those treating providers will be bound by the confidentiality rules of 42CFR Part 2 for all their clinical activities regardless of whether they are responsible for treatment pertaining more to mental illness issues than substance abuse.

Medical Emergency: Identifying information may be disclosed to medical personnel who have a need for information about a recipient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

GENERAL STANDARDS:

1. Most disclosures are permissible if the recipient or guardian has signed a specific consent to release information (see below).

2. The recipient cannot authorize release of the recipient's information if the information is to be used as part of a criminal investigation or prosecution of a recipient. Staff must contact the agency attorney under those circumstances.

3. There are limited exceptions to releasing information without the recipient's consent. Staff should contact the Office of Recipient Rights Officer/Privacy Officer if attempting to release recipient information without written consent.

4. Records of recipients who are receiving co-occurring treatment will not be bifurcated between mental health and substance abuse information. The record will be considered as a whole.

Exceptions: Commitment, ATOs and Adolescents, see sections below under procedure.

SPECIFIC CONSENT REQUIRED TO MEET 42CFR PART 2 AUTHORIZATION REQUIREMENTS:

1. The name or general designation of the program(s) making the disclosure;
2. The name of the individual or organization that will receive the disclosure;
3. The name of the recipient who is the subject of the disclosure;
4. The purpose or need for the disclosure;
5. A description of how much and what kind of information will be disclosed;
6. The recipient's right to revoke the consent;
7. CCMHS's ability to condition treatment, payment, enrollment or eligibility of benefits on the recipient agreeing to sign the consent, by stating either CCMHS may not condition services on the recipient signing the consent, or the consequences for the recipient refusing to sign the consent.
8. The date, event or condition upon which the consent expires if not previously revoked;
9. The signature of the recipient, guardian or legal representative;
10. The date on which the consent is signed;
11. The recipient shall receive a copy of the consent.

PROCEDURES TO COMPLY WITH 42 CFR PART 2:

A. Written Prohibition on Re-disclosure

1. Any disclosure made with written recipient consent must be accompanied by a written statement that the information disclosed is protected by federal law and that the individual or entity receiving the information cannot make any further disclosure.
2. Any verbal disclosures must be followed by a written statement regarding the prohibition on re-disclosure.
3. The recipient may sign a consent form that authorizes re-disclosure of information.

B. Internal Program Communications

1. Clinical staff who are identified as part of the co-occurring treatment team shall have access to information regarding recipients who are receiving co-occurring treatment.
2. Administrative staff who need information about a recipient who is receiving co-occurring treatment as part of their specific job duties shall have access to protected information.

3. All staff who are identified as needing protected information regarding recipients who are receiving co-occurring treatment shall be bound by the requirements of 42CFR2.

4. Regional crisis staff will have access to the recipient record in an emergency situation.

C. Commitment Hearings and Alternative Treatment Orders

1. Commitment Hearings and Alternative Treatment Orders are an exception to the rule that records will not be bifurcated.

2. Verbal testimony about a recipient's mental health diagnosis and treatment may be given at a hearing on commitment or an ATO. **Clinical records should not be taken to the courtroom.**

3. **No testimony about substance abuse diagnosis or treatment may be provided at a commitment hearing or a hearing on an alternative treatment order**.

D. Minor Consumers

1. CCMHS staff must always obtain the **minor's consent** for disclosures.

2. If the parent with legal custody or the guardian must consent to services, **the parent and the child must sign the authorization to release information**.

3. If the parent with legal custody or the guardian does not need to consent to services, the parent with legal custody or the guardian **cannot receive information about the minor's treatment unless the minor has signed a valid authorization**.

4. CCMHS staff may not disclose information about a minor or give access to the minor's records to a guardian ad litem **unless the minor signs an authorization or a court of competent jurisdiction issues an order that meets the requirements of 42CFR2.**

E. Mentally Incompetent and Deceased Consumers

1. Only legally appointed guardians may consent to release of information for recipients of co-occurring services.

2. CCMHS will not honor authorizations signed by anyone other than the court appointed guardian or the recipient. Authorizations signed by a personal representative (power of attorney) are not valid for co-occurring recipients.

F. Medical Emergencies

1. Immediately following the disclosure, the program shall document the disclosure in the recipient's record, setting forth in writing:

   a. The name of the medical personnel to whom the disclosure was made and their affiliation with any health care facility;

   b. The name of the individual making the disclosure;

   c. The date and time of the disclosure;

d. The nature of the emergency;

2. **Unless a valid authorization has been obtained, family members of recipients may not be contacted about the emergency.**

3. At intake, recipients should be asked to sign an authorization to release information in the event of an emergency.

G. Court-Ordered Disclosures

1. CCMHS staff will release information to a court only if the court order meets the requirements of 42CFR2.

2. Upon receipt of a court order to release information about a recipient who is receiving co-occurring treatment, staff shall contact the agency attorney or the Office of Recipient Rights.

H. Subpoenas and Warrants

1. CCMHS staff will honor subpoenas and warrants that meet the requirements of 42CFR2.

2. When presented with a subpoena or warrant, staff will contact the agency attorney.

3. A copy of 42CFR requirements for subpoenas and warrants shall be kept by the Recipient Rights Office.

I. Consumer Crimes on CCMHSB Premises or Against Program Personnel

1. Staff may report a crime or threatened crime by a recipient on CCMHS premises.

2. Staff may report threats to personnel made by a recipient.

3. Information that may be disclosed to law enforcement includes:

   a. Recipient’s name;

   b. Recipient’s address;

   c. Recipient’s last known whereabouts;

   d. Identifying the individual as a recipient of services.

4. Information regarding other recipients that may have been present is not permitted unless the other recipients have consented by signing an authorization form.

J. Child Abuse and Neglect Reporting

1. CCMHS staff shall report suspected child abuse or neglect.

2. There shall be no further release of information about recipients who are receiving co-occurring treatment after the initial report and written confirmation to Protective Services or law enforcement unless there is a valid authorization signed by the recipient or guardian or a court order that complies with 42CFR2.

K. Adult Abuse and Neglect Reports

1. Staff cannot identify a recipient who is receiving co-occurring treatment for the purpose of reporting suspected abuse of a vulnerable adult to Adult Protective Services.

2. Staff should contact the Office of Recipient Rights if they suspect abuse or neglect of a vulnerable adult.

L. Qualified Service Organization/Business Associates Agreements

1. CCMHS may communicate without a valid authorization to a QSO/BA that agrees:

   a. That in receiving, storing, processing, or otherwise dealing with any information from CCMHS about recipients, it is fully bound by HIPAA, the Michigan Mental Health Code and 42CFR.

   b. To resist, in judicial proceedings if necessary, any efforts to obtain access to information pertaining to recipients except as permitted by 42CFR2.

   c. To use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information;

   d. To report to CCMHS any use or disclosure of the protected information not provided for in the agreement of which it becomes aware;

   e. To ensure that any agent, including a subcontractor, to whom the QSO/BA provides the protected information received from CCMHS, or that it creates or receives on behalf of CCMHS, agrees to the same restrictions and conditions that apply through the QSO/BA agreement.

   f. To provide access to the protected information at the request of CCMHS, or to an individual as directed by CCMHS, to meet the requirements of 45CFR164.524.

   g. To make available its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of protected information received from CCMHS, or created or received by the QSO/BA on behalf of CCMHS, to CCMHS or Health and Human Services for purposes of determining the program's compliance with HIPAA.

   h. To document disclosures of protected information, and information related to such disclosures, as would be required for CCMHS to respond to a request by an individual for an accounting of disclosures in accordance with 45CFR164.528.

   i. To provide to either CCMHS or the requesting individual information necessary to allow CCMHS to respond to a request by an individual for an accounting of disclosures in accordance with 45CFR164.528.

   j. That CCMHS may terminate the agreement if it determines that the QSO/BA violated any material term;

   k. That upon termination of the agreement for any reason, the QSO/BA will not retain any copies of the protected information, and will return or destroy all protected information received from CCMH, or created or received by the QSO/BA on behalf of CCMHS;

l. That in the event that the QSO/BA determines that returning or destroying the protected information is infeasible, it will notify CCMHS of the conditions that make return or destruction infeasible and will extend the protections of the agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction infeasible, as long as it maintains the information.

2. CCMHS cannot enter into a QSO/BA with law enforcement agencies.

3. CCMHS cannot enter into a QSO/BA with another agency that provides the same drug or alcohol abuse diagnosis, treatment, counseling or referral services that CCMHS provides to its recipients.

M. Duty to Warn

1. **There is no "duty to warn" exception to release information without consent under 42 CFR2**.

2. However, if staff believe that they have a recipient who is receiving co-occurring treatment that has made a threat of violence against a third party that meets the requirements of MCL330.1946, they should contact their supervisor, the Program Director, the Executive Director or designee or the Recipient Rights Officer (see "Additional Procedures" below).

N. Michigan Protection and Advocacy Service

1. **There is no exception under 42CFR2 for release of information to Michigan Protection and Advocacy Service**.

2. Michigan Protection and Advocacy Service must have a release of information to obtain information about a recipient who receives co-occurring treatment, regardless if MP&A is investigating an allegation of abuse under MCL.

ADDITIONAL PROCEDURES FOR SUBSTANCE ABUSE RECORDS

A. Duty to Warn

1. When assessing and responding to recipient's threats of harm to others, information will be elicited through non-threatening inquiry. The following elements at a minimum need to be present for the Duty to Warn to take effect:

   a. A threat of physical violence;

   b. Against a reasonably identifiable third person;

   c. With apparent intent;

   d. And ability to carry out the threat;

   e. In the foreseeable future.

2. If, in the judgment of the worker, there is a Duty to Warn, the following steps must be taken:

   a. Notify your supervisor, Program Director, the Executive Director or designee, or the Recipient Rights Officer. In any case, the Executive Director or designee must be informed as soon as possible.

   b. Evaluate for involuntary or voluntary hospitalization.

c. Document everything in the recipient's progress notes, giving rationale for every decision.

3. If the third party who is threatened is a minor or is considered incompetent by other than age, the worker **must**:

   a. Do step B.

   b. Communicate with the Department of Human Services.

   c. Communicate with the parent or legal guardian.

4. In all such cases, treatment must be continued.

5. Documentation in recipient progress notes must be comprehensive and concise, giving rationale for every decision.

LEGAL AUTHORITY.

A. Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 748 (a), 750 and 946.

B. 45 CFR Part 164 section 512 (j)

C. 42 CFR Part 2 Subpart Subpart D.

Responding to a Subpoena

A. If, upon receipt of the subpoena there is sufficient time, contact will be made to the individual or entity issuing the subpoena, citing the federal regulations and explaining that, by law, no disclosure can be made until the standards have been complied with.

B. The subpoenaed record will be transported to the court in a sealed envelope marked "confidential."

C. Once an individual has been called and sworn as a witness in the proceedings, the subpoenaed individual will cite for the record, the applicable federal standards regulations (citation) governing disclosure to the court and will not disclose recipient information or respond to questions until so ordered by the court.

D. After complying with step 3, if the court orders the subpoenaed individual to respond to the questioning, the individual must state for the record their request to testify in chambers or after the courtroom has been cleared of all non-essential personnel.

E. Should the Court refuse to honor the Federal regulations and refuse to hold the remainder of the hearing in chambers or only in front of essential personnel, then the staff has done all that is required by the regulations. The staff may then disclose information determined by them to be in the best interest of the recipient and the therapeutic relationship.

LEGAL AUTHORITY.

A. Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 748 (a), and 750.

B. 45 CFR Part 164 section 512 (e).

C. 42 CFR Part 2 Subpart E. section 261.

RELEASE OF CONFIDENTIAL INFORMATION TO ORGANIZATIONS WITH OVERSIGHT RESPONSIBILITY and STATE OFFICE OF ADMINISTRATIVE HEARING AND RULES

The regulations governing the confidentiality of substance abuse treatment related information allow for the release of confidential information to the Michigan Department of Health and Human Services (MDHHS), or similar organizations with oversight responsibility, without specific consent of the recipient. All State Office of Administrative Hearings and Rules Staff, for the purpose of scheduling, hearing, and deciding requests for Medicaid Fair Hearings are agents of the MDHHS. All MDHHS staff are bound by the same confidentiality requirements as the substance abuse treatment staff and no confidential information can be released from MDHHS to a third party without the recipient's consent.

LEGAL AUTHORITY

A. Opinion from Martin Snider, Manager, MDHHS, 6/12/08

6/25/08
Updated 6-28-17

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 31, 2018 Consent.P4

RESCINDS: July 31, 2013

CATEGORY: Client Services

SUBJECT: Consent

POLICY: It is the policy of Copper Country Mental Health Services (CCMHS) Board that, except under life-threatening, emergency conditions, a written informed consent shall be obtained from a person served, from an empowered guardian or from the parent of a minor prior to: providing service; a substantial change in treatment which affects the risks or other consequences of treatment; providing medical services; chemotherapy; use of restrictive techniques; releasing or obtaining confidential information; and as required according to other Agency Policies and Procedures.

PURPOSE: To define the elements of informed consent, and establish procedures for evaluating comprehension, ensuring disclosure of relevant information and voluntariness before obtaining consent, and to define a mechanism for determining whether guardianship proceedings should be initiated, when an individual's capability to provide informed consent is in question.

PROCEDURE:

I. Elements of Informed Consent.

A. Legal competency: A person served who is an adult, and a minor when state law allows consent by a minor, shall be presumed legally competent. This presumption may be rebutted only by a court appointment of a guardian or exercise by a court of guardianship powers and only to the extent of the scope and duration of the guardianship. An individual shall be presumed legally competent regarding matters that are not within the scope and authority of the guardianship.

B. Knowledge: To consent, a person served or legal representative must have basic information about the procedure, risks, and other related consequences, and other relevant information. The standard governing required disclosure by a service provider is what a reasonable individual needs to know in order to make an informed decision. Other relevant information includes all of the following:

1. The purpose of the procedures.

2. A description of the attendant discomforts, risks, and benefits that can reasonably be expected.

3. A disclosure of appropriate alternatives advantageous to the person served.

4. An offer to answer further inquiries.

C. Comprehension: An individual must be able to understand what the personal implications of providing consent will be based upon the information provided.

D. Voluntariness: There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including

promises or assurances of privileges or freedom. There shall be an instruction that an individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the person served.

II. Informed consent shall be re-obtained if changes in circumstances substantially change the risks, other consequences, or benefits that were previously expected.

III. A written agreement documenting an informed consent shall not include any exculpatory language through which the individual, or a person consenting on the individual's behalf, waives or appears to waive, a legal right, including a release of a provider or its agents from liability for negligence. The agreement shall embody the basic elements of informed consent in the particular context. The individual, guardian, or parent consenting shall be given adequate opportunity to read the document before signing it. The requirement of a written consent shall not eliminate, where essential to the individual's understanding or otherwise deemed advisable, a reading of the document to the individual or an oral explanation in a language the individual understands. A note of the explanation and who made it shall be placed in the record along with the written consent.

IV. A consent is executed when it is signed by the appropriate individual.

V. An evaluation of an individual's ability to give consent shall precede any guardianship proceedings.

VI. When there is a question as to an individual's capability to provide informed consent, the Program Director of the program in which the individual is receiving services shall be so informed.

A. The Program Director shall review the available information.

1. On concurring that the individual lacks the ability to give informed consent, he/she shall direct the petition process for the individual.

2. When there is a lack of agreement as to the individual's ability to give informed consent, the issue is documented and referred to the Executive Director or designee.

3. The Executive Director or designee reviews the available information and may request additional evaluations and either: direct a petition for guardianship be initiated; or convene an Informed Consent Board as detailed in Administrative Rule 330.6013.

VII. Rights of a minor to consent:

A. A minor 14 years of age or older may request and receive mental health services, and a mental health professional may provide services on an outpatient basis (excluding pregnancy termination referral services and use of psychotropic drugs) without the consent or knowledge of the minor's parent, guardian, or person in loco parentis.

B. The minor's parent, guardian, or person in loco parentis is not informed of the services without the consent of the minor, unless the treating mental health professional determines a compelling need for disclosure based upon substantial probability of harm to the minor or another, and if the minor is notified of the treating professional's intent to inform.

C. Services provided to the minor are limited to not more than 12 sessions or four months per request and after these expire, the mental health professional terminates the services or, with the consent of the minor, notifies the parent, guardian, or person in loco parentis to obtain consent to provide further outpatient services.

VIII. The written informed consent shall:

A. Specify the expiration date. No written informed consent shall remain in effect longer than twelve (12) months.

   1. The consent will automatically expire when the purpose for which it was obtained has been achieved.

B. Not contain language which states or implies a waiver of Agency liability or any other legal right by the person giving the consent.

C. Be read or explained to the person giving consent, in language he/she can understand. The person giving consent shall be given ample time to read the document, to ask questions, and to fully understand the content.

D. Be obtained without intervention of any element of force, fraud, deceit, duress, overreaching or other ulterior form of constraint or coercion, including promises or assurances of freedom or privileges.

E. Include instruction that the individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the person served.

F. Be filed in the individual's clinical record.

IX. If a person served verbally agrees to participate in a treatment program and voluntarily participates in any recommended treatment program, but refuses to sign a Consent form, clinical services will not be denied. It should be documented on the Consent form both the individual's refusal to sign the Consent form, and their verbal agreement to participate in treatment. Regular attempts to encourage the person served to sign the Consent form should be documented as the treatment relationship develops.

X. Refusal or withdrawal of written informed consent shall be documented in the individual's clinical file.

APPLICATION: All programs.

CROSS REFERENCE:

CCMHS Policy – Guardianship

CCMHS Policy – Informed Consent to Psychotropic Chemotherapy

CCMHS Policy – Use & Release of Protected Health Information

CCMHS Policy - Recipient Rights Specific to Recipients Receiving Integrated Treatment for Co-Occurring Disorders

CCMHS Policy - Photographing and Fingerprinting Recipients

CCMHS Policy – Behavioral Treatment Committee

Mental Health Code Section 707 Administrative Rules 330.6013, 330.7003

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: June 28, 2017 Consumer Labor.P4

RESCINDS: April 24, 2013

CATEGORY: Recipient Rights

SUBJECT: Consumer Labor

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that recipients are permitted to work for the Agency under certain conditions. These conditions shall meet the therapeutic needs of the recipients and the basic human dignity to which a recipient is entitled and be consistent with regulations and policies of the United States Department of Labor, other federal departments and rules of the Department of Health and Human Services.

PURPOSE: The purpose of this procedure is to set forth conditions under which a recipient may work for the Agency.

DEFINITIONS:

Work: Any directed activity, or series of related activities, which result in benefit to the economy of the Agency or in a contribution to its maintenance, or in the production of a salable product.

Compensation: The receipt of money for work (including work performance in an occupational training program) which is available to the recipient, to be used at his or her discretion.

Prevailing Wage: The wage paid to non-disabled workers in nearby industry or the surrounding community for essentially the same type, quality of work or work requiring comparable skills.

PROCEDURE:

I. A recipient may perform personal housekeeping tasks without compensation.

A. Personal housekeeping tasks, performed in a group living arrangement, include, but are not limited to, such things as:

1. meal planning, food purchasing, food preparation, table setting, serving, dishwashing, etc.;
2. household cleaning, laundry;
3. clothes repair;
4. light yard and house maintenance (simple carpentry, gardening, etc);
5. general household shopping, including clothing.

B. No task may be performed for the convenience of staff.

C. Participating in housekeeping tasks must be authorized in the recipient's Individual Plan of Service.

II. A recipient is permitted to work for Copper Country Mental Health Services under the following conditions:

A. The work is part of the recipient's Individual Plan of Service and is approved by the Case Manager.

1. Approval shall not be withheld unless reasons explaining how the work is inconsistent with the Individual Plan of Service are stated in the record.

2. The work cannot interfere with other ongoing treatment or habilitation programs suitable for the recipient.

3. Recipient work may not consume more than six (6) hours of a recipient's day unless approved by the Executive Director or the Clinical Director.

B. The work is performed voluntarily.

C. The recipient receives compensation commensurate with the economic value of work.

1. For work performed that contributes to the operation and maintenance of the facility the recipient is paid at least the prevailing minimum wage except when an appropriate certificate has been obtained by the Agency in accordance with regulations and guidelines issued under the Fair Labor Standards Act, as needed.

2. A recipient who performs labor other than as described in C.1. shall be compensated an appropriate amount if an economic benefit to another individual or agency results from this labor.

D. The work project complies with applicable law and regulation.

E. Under no circumstances shall work performance be used as a condition to discharge a recipient from mental health services (other than work-related services) nor to deny other privileges to the recipient.

III. When a recipient's Individual Plan of Service includes assignment to occupational or vocational training or work, specific work objectives of anticipated progress should be included in the Individual Plan of Service along with reasons for the assignments.

A. If this assignment involves work to be accomplished for the Agency (as defined above), the recipient must be compensated as in II.C.1. above.

B. One half of any compensation paid to a recipient under this policy is exempt from collection under the Mental Health Code as payment for services rendered by Copper Country Mental Health.

CROSS REFERENCE:

N/A

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Contracting for Clinical Services.P16

RESCINDS: December 8, 2021

CATEGORY: Contracts and Credentialing

SUBJECT: Contracting for Clinical Services

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) that all contracts between the Board and organizational providers and independent (non-employee) providers comply with all applicable laws and regulations.

PURPOSE: This policy is written to address statutes, regulations, and guidelines applicable when clinical services are provided through contracts with organizations and individuals. CCMHS cannot contract with persons or organizations who: are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department; or have been convicted of a felony; or have been convicted of a misdemeanor that has a direct relationship to the duties of the position, for example, a conviction of Medicaid fraud under $500 would exclude a person from positions which require working with Medicaid recipients (Section 1128(a) and (b) of the Social Security Act).

DEFINITIONS:

Credentialing: The process of validating that the organizational provider is licensed or certified as necessary to operate in the State and has not been excluded from Medicaid or Medicare participation and that the organization properly credentials their directly employed and subcontracted direct service providers. Credentialing includes verifying and evaluating the applicant for information including but not limited to: state licensure information; a copy of the facility's liability insurance declaration; additional requirements per Michigan Medicaid Provider rules; a current copy of accreditation status; and a signed and dated attestation of authorized representative for the facility attesting the information is accurate and complete. Organizational providers are providers with whom CCMHS contracts and that directly employ and/or contract with individual providers to provide healthcare services. Examples of organizational providers include, but are not limited to hospitals, residential providers, and vocational providers. (As defined by MDHHS Contract P.6.4.3.1)

Deliverables: Services or work product to be performed including status reports, recommendations, analysis and other reports and documentation as required.

Organizational Providers: Entities that directly employ and/or contract with individuals to provide health care services. Examples of organizational providers include but are not limited to: Community Mental Health Services Programs; hospitals; nursing homes; homes for the aged; psychiatric hospitals, units and partial hospitalization programs; substance abuse programs; and home health agencies and specialized residential providers.

Privileging: The process of determining a health care professional's current skill and competence to perform specific diagnostic or therapeutic procedures that the professional requests to perform as a participant in or an affiliate of a healthcare facility or system. The result of privileging is that a practitioner is permitted by a healthcare organization or network to conduct those specific procedures. (American Managed Behavioral Healthcare Association)

Provider: Any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State in which he or she delivers the services.

Qualified Behavioral Health Practitioner: A person certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the education, experiential, or competency requirements necessary to provide mental health or alcohol and other drug services.

Sanctions: Actions including, but not limited to, a monetary penalty imposed on the contract provider; termination of the contract between CCMHS and the provider.

PROCEDURE:

I. AUTHORITY

A. The Executive Director or his designee has the sole authority to negotiate contracts between the Board and clinical service providers.

B. The contract will provide a limit on the total expenditures authorized thereunder during any one fiscal year. Should that limit provide for total payments to any one individual or organization in excess of $5,000, it will require approval by the Copper Country Mental Health Services Board in accordance with its By-Laws then in effect.

C. Upon execution by all parties, the signed original is returned to and retained by CCMHS and the provider keeps a copy.

II. CONTENTS OF CONTRACTS:

A. All contracts will be written using standardized templates and contain assurances found in standard boilerplate language including, but not necessarily limited to:

- Equal Employment Opportunity,
- Fair Labor Standards Act, Americans with Disabilities Act,
- Balanced Budget Act,
- Fair Housing Act,
- Michigan Persons with Disabilities Act,
- Civil Rights Act,
- Michigan Mandatory Special Education Act,
- Anti-Kickback Act,
- Public Act 469 of 1980, being MCL 15.361 et seq., otherwise known as the Whistle Blowers Protection Act,
- OSHA and/or MIOSHA Regulations,
- The Child Protection Act,
- Adult Protective Services Act and Assault Reporting,
- The Anti-Lobbying Act,
- Pro Children Act,
- The Hatch Act, The Drug Free Workplace Act,
- HIPAA Regulations,
- Elliott Larsen Civil Rights Act,
- Age Discrimination Act,
- Federal Rehabilitation Act

B. Additional elements addressing:

- Duty to treat and accept referrals;
- Prior authorization requirements;
- Access standards and treatment time lines;
- Screenings
- Relationships with other providers;
- Reporting requirements;
- Provisions for the provider to participate in CCMHS's quality improvement and utilization review activities, as appropriate;
- Payment arrangements for services and withholds that may apply to provider failing to meet deliverables;
- Anti-delegation clause;
- Office of Civil Rights Policy Guidelines on Title VI "Prohibition Against Discrimination as it Affects Persons with Limited English Proficiency",
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements,
- Debarment and Suspension,
- Staffing and training requirements,
- Parity (42CFR part 438 subpart K),
- Audits/Reviews,
- Grievance Procedures,
- Liability,
- Insurance

C. Provisions for the immediate transfer of people receiving services to a different provider if their health or safety is in jeopardy;

D. Termination clause, remedial actions clause and requirements to follow CCMHS standards;

E. Will not prohibit a provider from discussing treatment options with a person that may not reflect CCMHS's position or may not be covered by CCMH;

F. Will not prohibit a provider from advocating on behalf of the person receiving services in any grievance or utilization review process, or individual authorization process to obtain necessary health care services;

G. The frequency with which performance reports and other reporting documentation will be submitted;

H. Requirement for provider to meet Medicaid accessibility standards as established in Medicaid policy and the Michigan Department of Community Health (MDCH) contract;

I. Complete description of the scope of work, all expected deliverables, rates and terms of payments for such rates, and the contract period;

J. Any changes in rates or contract provisions are communicated to providers at least 30 days in advance, through written correspondence and may include a contract amendment;

K. Names of contact representatives for CCMHS and the provider;

L. Requirements for credentialing/re-credentials and privileging of providers, criminal background checks, and checks to ensure the provider has not been or is currently sanctioned by the Medicaid program;

M. Will prohibit the provider from employing individuals to provide services who are excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Social Security Act;

N. Will require compliance with:

1. all Recipient Rights provisions of the Michigan Mental Health Code and Administrative Rules;
2. all other applicable policies and procedures of CCMHS.

O. Will prohibit the interests of the parties to be assignable;

P. Will prohibit actual or apparent conflicts of interest;

Q. Statement that CCMHS will be held harmless from any losses caused by the other party(ies) to the contract. Further, MDHHS is not a party to the contract and therefore not a party to any employer/employee relationship with the provider;

R. Statement that the provider is responsible for the wages, employment taxes, insurance and workers' compensation coverage for the provider's employees;

S. Each provision of the contract will be deemed to be severable from all other provisions of the contract and, if one or more of the provisions are declared invalid, the remaining provisions of the contract will remain in full force and effect; and

T. The contract will be governed by Michigan Law and will prohibit modifications except in writing.

III. REPORTING REQUIREMENTS

A. Documentation Requirements - CCMHS is required by NorthCare Network to have a documented process to monitor and verify that providers are providing services in accordance with those authorized in the IPOS, including amount, scope, duration, start and stop times, and that includes ensuring no overlap in services. Services must be clearly documented in the provider's record and must meet documentation standards.

CCMHS will give each provider instructions about how to fulfill this requirement.

B. Event Notification - In addition to other reporting requirements outlined in the contract, the provider will immediately notify CCMHS of the following events:

1. Any death of a person receiving services that occurs as a result of an employee's suspected action or inaction, or any death that is the subject of a recipient rights licensing or police investigation.
2. Relocation of a person's placement due to licensing issues.
3. An occurrence that requires the relocation of any provider's service site, governance, or administrative operation for more than 24 hours.
4. The conviction or adverse change in licensure or certification of the individual provider, organization or of any employee of the organization as soon as the provider is aware of or should have been aware of the change.

Notification of these events will be made telephonically or by other forms of communication to the contract manager or management staff at CCMHS, who will in turn notify the NorthCare Network and/or MDHHS.

IV. CREDENTIALING AND RE-CREDENTIALING OF ORGANIZATIONAL PROVIDER

A. Credentialing Organizational Providers

1. Facilities and other organizational providers must credential staff according to their accreditation and contract with CCMHS. In addition, CCMHS verifies that the organizational provider is licensed or certified as necessary to operate in Michigan, and has not been excluded from Medicaid or Medicare participation relating to procurement and health care issues.

2. All organizational providers are expected to maintain compliance with the "Credentialing Program" Policy and Procedure, Paragraph II which addresses "Credentialing and Re-credentialing of Facilities and Other Organizational Providers."

    a. For providers of specialized residential services, CCMHS will also monitor: Michigan Department of Licensing and Regulatory Affairs (LARA) –michigan.gov/lara - to verify that the provider is licensed by MDHHS to provide specialized residential care in a licensed setting and to review on-line reports.

B. Deemed Status

CCMHS may recognize and accept credentialing activities conducted by another CMHSP for any provider that delivers healthcare services to both CCMHS and the other CMHSP. In such situations, CCMHS shall maintain copies of the credentialing CMHSP's decisions in the provider's contract file.

C. Notification of Adverse Credentialing Decision

An individual practitioner or organizational provider that is denied credentialing or re-credentialing by CCMHS will be informed of the reasons for the adverse credentialing decision in writing.

D. Appeal Process

If an organizational provider, group or individually licensed provider disagrees with a determination by CCMHS in the application process or during review of a provider's status, please refer to

"Credentialing Program" Policy and Procedure, Paragraph VII, which addresses how the provider may proceed to have the matter reviewed at a higher level.

V. CREDENTIALING/RE-CREDENTIALING AND PRIVILEGING ORGANIZATIONAL PROVIDER'S EMPLOYEES

A. All organizational providers' employees who provide clinical services must be credentialed and privileged in the same manner or to the same degree as CCHMS practitioners and in accordance with CCMHS's credentialing and privileging policies.

B. Prior to a contract for services being enacted, the provider will attest in writing to CCMHS that services under the contract will only be provided by practitioners who meet all required credentialing, licensure, and/or certification.

C. Thereafter, at the time of the annual site review, the reviewer will verify appropriate proof of credentialing, licensure, and/or certification as a part of the site review process.

VI. BACKGROUND CHECKS

A. All contract providers of clinical services must conduct and/or undergo criminal background checks and a driving record check if providing transportation to persons receiving services, in the same manner or to the same degree as CCHMS employees in accordance with the CCMHS's Background Check

policy. This includes fingerprinting for any person who has regular access to a person residing in a licensed adult foster care home operated by CCMHS, or to the person's property, financial information, medical records, treatment information, or any other identifying information.

B. Prior to a contract for services being enacted, the provider will attest in writing to CCMHS that services under the contract will only be provided by practitioners who meet all required background checks.

C. Thereafter, at the time of the annual site review, the reviewer will verify appropriate proof of background checks.

VII. TRAINING REQUIREMENTS

A. All contract providers of medical or clinical services must receive initial and ongoing training updates that, at a minimum, includes:

1. Rights of the person served.
2. Person- and family-centered services.
3. Prevention of workplace violence.
4. Confidentiality requirements.
5. Cultural competency.
6. Expectations regarding professional and ethical conduct.
7. Reporting of incidents and adverse events.
8. Advanced directives/crisis planning.
9. Regulatory management/compliance efforts.
10. Information about the grievance system, including the person's right to file grievances, timeframes, availability of assistance and contact information.

VIII. RECIPIENT RIGHTS

All contract providers who are allowed/required by contract to establish their own rights system will require that the provider's Recipient Rights Officer, Advisor and Alternate attend and successfully complete the Basic Skills Training programs offered by the MDHHS's Office of Recipient Rights within three (3) months of hire. In addition, every three (3) years during their employment, the Rights Officer/Advisor and any alternate(s) must complete a Recipient Rights Update Training as specified by the MDHHS.

IX. ANNUAL EVALUATION AND SANCTIONS

A. The performance of all providers (organizational and individual) is assessed at least annually to determine compliance with contract requirements and whether or not the contract will be renewed.

B. CCMHS will require a written Plan of Correction within thirty (30) days, for any areas of non-compliance, including credentialing and re-credentialing, background checks and driving record checks for individuals who transport persons receiving services. See CCMH Policy and Procedure entitled "Contract Oversight, Monitoring and Evaluation" for specific procedures.

C. In addition to termination as a result of being included on an Exclusions Database, providers may be removed for expiration of licenses and/or other adverse changes in licensure or certification status. Please refer to "Credentialing Program" Policy and Procedure, paragraph VI, for information.

D. CCMHS may immediately suspend, pending investigation, the participation status of a contract provider who, in the opinion of the Medical Director or Associate Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to health, welfare, or safety of persons served. An immediate referral will be made to the Office of Recipient Rights in such an event.

X. COMMUNICATION WITH PROVIDERS

A. Whenever possible, persons receiving services from a provider will be given written notice of any change regarding the names, locations, telephone numbers of, and non-English languages spoken by contract providers at least thirty (30) days before the intended effective date of change.

B. CCMHS will make a good faith effort to give written notice of termination of a contracted provider within fifteen (15) days after receipt or issuance of the termination notice, to each person who received primary care from, or was seen on a regular basis by, the terminated provider.

C. New contract providers are directed to the Agency's Provider Manual on the website at www.cccmh.org/provider-information for policies, procedures and general information. A copy of the Provider Manual will be mailed upon request.

D. When changes are made to any policies, rules/regulations or procedures that affect providers, the providers are informed by e-mail and the changes are included in the Provider Manual on the website.

E. Providers with questions regarding the Provider Manual or contract provisions may contact a CCMHS representative.

F. Providers are encouraged to participate on Agency committees that address how CCMHS and its providers can provide the best services. Providers with suggestions and guidance information about how to improve services can contact CCMHS' Customer Services Coordinator.

G. CCMHS will maintain ongoing communication with its providers regarding changes that impact compliance.

CROSS REFERENCE:

CCMHS Policy – Contract Provider Oversight, Monitoring and Evaluation

CCMHS Policy - Procurement of Goods and Services

CCMHS Policy – Credentialing Program

CCMHS Policy – Clinical Privileging of Individual Practitioners

CCMHS Policy – Background Checks

NorthCare Network Policy – Procurement of Goods and Services

NorthCare Network Policy – Provider Communication

NorthCare Network Policy – Provider Oversight, Monitoring & Evaluation

NorthCare Network Policy – Provider Selection Policy

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 10

Social Security Act-Section 1128(a)& (b)& Section 1902(a)(39)

42 CFR 438.214 Provider Selection

COPPER COUNTRY MENTAL HEALTH SERVICES
CONTRACTING GUIDELINE

CONTRACTUAL PLACEMENTS OUT-OF-COUNTY & WITHIN CATCHMENT AREA

PURPOSE: To establish guidelines to ensure that consumers who receive services in contractual residential placements have Individual Plans of Service and receive service monitoring that meet the standards of CCMHS.

PROCEDURE:

Each consumer who is placed in a contractual setting is assigned a CCMHS case manager/supports coordinator who is responsible to ensure that the Individual Plan of Service is developed and monitored and that other documentation is maintained according to CCMHS standards. Documentation requirements for those persons receiving service in contractual settings is comparable to those who receive service in directly operated residential settings.

INDIVIDUAL PLAN OF SERVICE

Prior to the person-centered planning meeting, the assigned case manager/supports coordinator will contact the person and/or the guardian to complete the pre-planning stage of the person-centered planning process.

All "annual" paperwork must be completed at this time, including Psychosocial Assessments, Level of Functioning Assessments, etc.

If at all possible, the assigned case manager/supports coordinator will attend the person-centered planning meeting in person. If unable to attend in person he/she must participate by phone.

The case manager/supports coordinator will either complete the Individual Plan of Service document using the CCMHS format; or ensure that the person receives an IPOS that meets all CCMHS standards by reviewing the IPOS document developed by the provider. He/she is also responsible to ensure that the consumer or the guardian receive a copy of the plan within 15 business days of the meeting as well as the Adequate Notice and any other documents that may be required (see attached IPOS checklists).

Services must be authorized using the CCMHS standard authorization process.

ONGOING CLINICAL MONITORING

The case manager/supports coordinator is responsible to maintain ongoing contact with the service provider and to ensure that all required clinical documentation is obtained, including but not necessarily limited to assessments, contact notes, medical records, incident reports and other documentation that supports service delivery.

The case manager/supports coordinator will contact the service provider by phone at least monthly and document the contact in a progress note, using the CCMHS format. The case manager/supports coordinator is responsible to ensure that the IPOS is being carried out as planned.

The case manager/supports coordinator or a designee will make an in-person visit to the consumer at least once each year.

ADMINISTRATIVE MONITORING

At least one administrative monitoring visit will occur each year. This visit will be documented using the "Regional Contract Provider Review" form (see attached). It can be completed by a CCMHS staff person or another CMH staff person from the region as long as it is made available to CCMHS.

In addition, an annual Recipient Rights Office visit is required. Again, this can be completed by the CCMHS staff person or a staff person from another CMH as long as the report is made available to CCMHS.

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Corporate Compliance.P5

RESCINDS: May 29, 2019

CATEGORY: Corporate Compliance

SUBJECT: Corporate Compliance

POLICY: Copper Country Mental Health Services Board (CCMHS) is dedicated to the delivery of behavioral health care in an environment characterized by strict conformance with the highest standards of accountability for administration, clinical, business, marketing and financial management. CCMHS' leadership is fully committed to the need to prevent and detect illegal or unethical activity and/or fraud, waste and abuse and therefore, to the development of a formal corporate compliance program to ensure ongoing monitoring and conformance with all legal and regulatory requirements. Further, CCMHS is committed to the establishment, implementation and maintenance of a corporate compliance program that emphasizes:

A. Prevention of wrong-doing – whether intentional or unintentional,

B. Immediate reporting and investigation of questionable activities and practices without consequences to the reporting party, and

C. Timely correction of any situation, which puts the organization, its leadership or staff, funding sources or consumers at risk.

PURPOSE: The purpose of this policy is to:

A. Articulate CCMHS' commitment to a process that meets the Federal Sentencing Guidelines, including the recommendations and standards promulgated by the Health and Human Services (HHS) Office of Inspector General (OIG) for identifying and mitigating risk including but not limited to, fraud, waste, or abuse and improving internal controls; and,

B. To effectively prevent and detect criminal conduct and to reduce the likelihood of being found to have recklessly disregarded or deliberately violated the law; and

C. Ensure compliance with all applicable Federal and State Laws, Guidelines, Rules and Regulations including NorthCare Network's Compliance policies and procedures.

DEFINITIONS

Abuse: - means provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

Corporate Compliance: – Corporate compliance is defined as following the law and the organization's policies and procedures. The purpose of corporate compliance activity is to prevent fraud, abuse, waste and unethical conduct.

Ethical Conduct: – Ethical conduct is defined as working in a manner that is honest, legal and respectful of others. Ethical conduct also describes behavior that falls within the boundaries established by the organization's mission, vision and values statements.

Fraud (Federal False Claims Act): - means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR § 455.2)

Waste: - means overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

PROCEDURE:

I. By formal resolution, the Board of Directors has delegated overall responsibility for the Corporate Compliance Program to the Executive Director. The Executive Director will formally designate a Corporate Compliance Officer and Compliance Committee, monitor CCMHS's corporate compliance program and provide periodic and regular reports to the Board of Directors on matters pertaining to the program.

II. The Corporate Compliance Officer (CCO) shall:

A. Chair the organization's Corporate Compliance Team and serve as CCMHS's primary point of contact for all corporate compliance issues, including scheduling team meetings, reporting on team activities and making recommendations to the Executive Director and/or Board of Directors as required;

B. Develop, implement and monitor – on a regular and consistent basis- CCMHS's Corporate Compliance Plan, including all internal and external monitoring, auditing, investigative and reporting processes, procedures and systems;

C. Prepare, submit and present periodic reports to the Executive Director and/or Board of Directors as may be required to provide clear communication to the organization's leadership for corporate compliance oversight;

D. Identify and review periodic reports to ensure overall compliance of the organization;

E. Implement and publicize a reporting process that encourages employees and contract providers to report compliance-related concerns;

F. Maintain a system to document and track reported compliance issues and inquiries;

G. Objectively, uniformly, and consistently coordinate and/or complete review and/or investigations of suspected fraud, waste, and abuse or reported violations of applicable law, regulations, guidelines and policy;

H. Ensure documentation of all actions taken in response to a compliance issue report, including any steps taken to address identified improper conduct, if any;

I. Inform complainant of expectations of a timely response, confidentiality, non-retaliation, and progress reports regarding where in the process the review/investigation is;

J. Ensure proper follow-up on resolution of compliance issues and concerns; and

K. Ensure, in all situations where it is appropriate, that CCMHS initiates voluntary disclosure or reporting of violations of civil, criminal, or administrative law to appropriate third-party law enforcement or regulatory agencies. Self-Disclosure must follow the Office of Inspector General's Provider Self-Disclosure Protocol (42 USC 1320a-7b(f)) and the requirements of the Federal False Claims Act, (31 USC 3729-3733).

III. If a confirmed compliance issue is determined and, if after consultation with legal counsel, it is determined a violation of a civil or criminal, federal or state law has occurred, the violation will be reported to the appropriate government agency as soon as possible.

IV. The CCO shall submit an annual report to the Quality Improvement Committee, the Executive Director and Board of Directors. Annual reports will, include at a minimum:

A. A summary of all allegations, investigations and/or complaints processed in the preceding 12 months in conjunction with the corporate compliance program;

B. A complete description of all corrective action(s) taken;

C. Any recommendations for changes to the organization's policies and/or procedures; and

D. Evaluation of the effectiveness of the Corporate Compliance Plan.

V. In the performance of his/her duties, the CCO shall have direct and unimpeded access to the Executive Director, Board of Directors and the organization's accounting firm and/or legal counsel for matters pertaining to corporate compliance.

CROSS REFERENCE:

Board of Directors Corporate Compliance Resolution

CCMHS Policy – Compliance Committee

CCMHS Policy – Deficit Reduction Act

CCMHS Policy – Corporate Compliance Investigations

CCMHS Corporate Compliance Plan

NorthCare Network Compliance Policies and Procedures

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: January 31, 2024 Credentialing Program.P7

RESCINDS: June 27, 2018

CATEGORY: Contracts and Credentialing

SUBJECT: Credentialing Program

POLICY: Copper Country Mental Health Services Board (CCMHS) implements a comprehensive credentialing/re-credentialing plan that includes continuous credential monitoring, thereby assuring safety of persons served and provision of services by competent and qualified providers. Providers in bordering states are held to the same standards and procedures for credentialing and re-credentialing and must meet all applicable licensing and certification requirements of their state.

PURPOSE: CCMHS adopts this policy to assure that providers of clinical oversight, management, and direct services are fully qualified and in good standing. Accordingly, those providers are properly credentialed and privileged to perform the assignments detailed in their job descriptions. CCMHS utilizes continuous credentialing as described in this policy to monitor providers and to sanction providers who are out of compliance with CCMHS's credentialing standards. This process allows CCMHS to maintain a high quality of care and to respond more quickly when a provider ceases to be in compliance with credentialing criteria. This policy does not establish the acceptable scope of practice for any of the identified providers, nor does it imply that any service delivered by the providers identified in the body of the policy is Medicaid-billable or reimbursable.

DEFINITIONS:

Clean Application: The provider has completed all applicable sections of the NorthCare Network Credentialing Application; where indicated the provider has signed, initialed and dated the credentialing application; and all necessary support documentation has been submitted and is included with the credentialing application.

Credentialing Committee: A committee of professional peers led by a Senior Clinical Staff Person. The committee membership includes ad hoc members as well as required members to assure appropriate peer review for each provider. Delegation of this function to an organizational provider must be monitored for the same standards required for CCMHS's Credentialing Committee.

Credentialing Individual Providers: The process of reviewing, verifying, and evaluating a practitioner's credentials (i.e., professional education, clinical training, licensure, board and other certification, clinical experience, letters of reference, other professional qualifications, and disciplinary actions) to establish the presence of the specialized professional background required for membership, affiliation, or a position within a healthcare organization or system. The result of credentialing is that a practitioner is granted membership in a medical staff or provider panel. (As defined by the American Society of Addiction Medicine and the American Managed Behavioral Healthcare Association)

Credentialing Organizational Providers and Facilities: The process of validating that the organizational

provider is licensed or certified as necessary to operate in the State and has not been excluded from Medicaid or Medicare participation and that the organization properly credentials their directly employed and subcontracted direct service providers. Credentialing includes verifying and evaluating the applicant for information including but not limited to: State licensure information; a copy of the facility's liability insurance declaration; additional requirements per Michigan Medicaid Provider rules; a current copy of accreditation status; and a signed and dated attestation of authorized representative for the facility attesting the information is accurate and complete. Organizational providers are providers with whom CCMHS contracts and that directly employ and/or contract with individual providers to provide healthcare services. Examples of organizational providers include, but are not limited to hospitals, residential providers, and vocational providers. (As defined by MDHHS Contract P.6.4.3.1)

Databank: The National Practitioner Databank (NPDB) is an information clearinghouse created by Congress to improve health care quality and reduce health care fraud and abuse in the United States. The NPDB is also referred to as the Data Bank. The Data Bank is primarily an alert or flagging system intended to facilitate a comprehensive review of the professional credentials of health care practitioners, providers and suppliers.

Grievance: A formal complaint made based on something that somebody feels is unfair.

PIHP: The Prepaid Inpatient Health Plan under contract with the Department of Health and Human Services to provide managed behavioral health services to Medicaid eligible people.

Practitioner/Provider: Any individual that is engaged in the delivery of health care services and is legally authorized to do so by the State in which he or she delivers the services.

Primary Source Verification: Verification based on information obtained directly from the issuing source of the credential.

Senior Clinical Staff Person: A senior clinical staff person who has: current, unrestricted clinical licenses(s); qualifications to perform clinical oversight for the services provided; post-graduate experience in direct patient care; and Board certification (if the senior clinical staff person is an M.D. or D.O.).

PROCEDURES:

I. Credentialing Individual Practitioners

A. Healthcare Professionals that Require Credentialing

Credentialing and re-credentialing must be conducted and documented for at least the following healthcare providers:

1. Physicians (MDs and DOs)
2. Physician Assistants (PAs)
3. Social Workers - Licensed and Limited Licensed Master's (LMSWs and LLMSWs)
4. Psychologists - Licensed, Limited Licensed and Temporary Limited Licensed (LPs, LLPs, and TLLPs)
5. Bachelor Social Workers - Licensed and Limited Licensed (LBSWs and LLBSWs)
6. Registered Social Service Technicians (SSTs)
7. Registered Nurses (RNs)
8. Licensed Practical Nurses (LPNs)
9. Nurse Practitioners (NPs)

10. Occupational Therapists (OTs)
11. Occupational Therapist Assistants (OTAs)
12. Physical Therapists (PTs)
13. Physical Therapist Assistants (PTAs)
14. Speech Pathologists
15. Dieticians
16. Limited Licensed or Licensed Professional Counselors
17. Certified Addictions Counselors CADC -Certified Alcohol & Drug Counselor – Michigan or CAADC-Certified Advanced Alcohol & Drug Counselor or CADC & CAADC through International Credentialing and Reciprocity Council (IC & RC)
18. Certified Clinical Supervisors (CCS), CCS-IC & RC, CCS-Michigan
19. Certified Criminal Justice Professionals (CCJP)
20. Certified Co-Occurring Disorders: CCDP-Certified Co-Occurring Disorders Professional or CCDP-D-Certified Co-Occurring Disorders Professional-Diplomat through IC &RC& MI
21. Board Certified Behavior Analyst
22. Student Interns in approved Master's level educational program for social work, counseling, psychology, marriage and family therapy
23. Other behavioral healthcare specialists license, certified or registered by the State

B. Non-discrimination

CCMHS's credentialing and re-credentialing process does not discriminate against:

1. A healthcare professional, solely on the basis of license, registration or certification; or
2. A healthcare professional who serves high-risk populations or who specializes in the treatment of conditions that require costly treatment.

C. Excluded/Sanctioned Providers

CCMHS prohibits employment or contracts with providers who are excluded from participation under either Medicare or Medicaid. CCMHS completes Center for Medicare and Medicaid Services (CMS) queries on providers at http://exclusion.oig.hhs.gov as part of the application process. A complete list of sanctioned providers is available on the Michigan Department of Health and Human Services website at www.michigan.gov/mdhhs. CCMHS utilizes the Data Bank continuous query for monitoring excluded/ sanctioned providers. If CCMHS receives notice or becomes aware that an employed staff or contracted provider has become an Excluded Party or Sanctioned Provider, CCMHS will terminate employment or the contract with the staff or provider upon verification of the information.

CCMHS will notify NorthCare's CEO and/or Compliance Officer immediately if search results indicate that any of their network's provider entities, or individuals or entities with ownership or control interests in CCMHS are on any of the exclusions databases.

D. Provider Credentialing Application

1. At the time of initial credentialing, all prospective providers shall complete NorthCare's Network Credentialing Application.

2. CCMHS will provide a cover letter to inform all credentialing applicants about the specific staff to contact in order to:

   a. Communicate about the status of their credentialing request.

   b. Have the opportunity to correct incomplete, inaccurate or conflicting credentialing information.

E. Background Check/Primary Source Verification

Primary and secondary source verification is completed within six months of the dated application. Telephone verification is acceptable if the call is documented and includes the name of the person at the issuing entity. The documentation is signed and dated by the CCMHS staff that obtains the information.

Following completion of the provider credentialing application, including submission of required support documentation, CCMHS's HR Department completes primary source verification on the following:

1. Licensure or certification.
2. Board certification, or highest level of credentials attained, if applicable, or completion of any required internships, residency programs, or other post-graduate training.
3. Documentation of graduation from an accredited school. CCMHS requires a copy of the provider's terminal degree diploma, if available, and official transcripts and/or LARA License.
4. Data Bank query.
5. If the individual practitioner undergoing credentialing is a physician, the physician profile information obtained from the American Medical Association may be used to satisfy the primary source requirements of (1), (2), and (3) above.

   CCMHS may require prospective providers that will be directly employed by CCMHS to complete fingerprinting with the Michigan Long Term Care Background Check data base. This process includes the following background checks: Nurse Aid Registry (NAR), Offender Tracking Information System (OTIS), Public Sex Offender Registry (PSOR), System for Award Management (SAM) and the U.S. Health and Human Services Medicare/Medicaid Exclusion List (OIG). Additionally, CCMHS checks Internet Criminal History Access Tool ICHAT) and the sanctioned provider list for the State of Michigan. The fingerprinting process determines if the provider is excluded from employment due to criminal history. Fingerprints remain in the database as a means of continuous monitoring of criminal record.

F. Credentialing File

CCMHS maintains a credentialing file for each credentialed provider. This file shall contain:

1. A completed provider credentialing application.

2. Copy of professional license(s) and verification of the license(s).
3. Board Certification, if applicable.
4. Copy of diploma, if available.
5. Official transcripts.
6. Background check.
7. Fingerprinting results (CCMHS employees only).
8. Data Bank query result.
9. 3 Written letters of reference.
10. Authorization of Clinical Privileges.
11. Proof of liability insurance, if applicable.
12. Any other pertinent information used in determining whether or not the provider met the credentialing standards.

CCMHS's HR Department completes a credentialing checklist, which is contained in the credentialing file. This checklist is used as a review method to assure completeness and accuracy of information in the file, as well as to identify and clarify any conflicting information. This checklist is completed before the file is given to the Credentialing Committee.

G. Confidentiality

Credentialing files and information, along with the minutes and records of the Credentialing Committee proceedings, will be maintained in a secure environment with access limited to CCMHS credentialing staff and site reviewers as necessary. To maintain the confidentiality and security of credential files, CCMHS's credential files are stored in a secure file room in CCMHS's HR Department. Access to credentialing files is limited to authorized credentialing personnel. CCMHS's Credentialing Committee will have a list of all staff with access to credentialing files. All electronic information related to credentialing is password protected and computers are locked when an employee leaves their workstation.

All CCMHS Credentialing Committee members, as well as anyone handling credentialing information (e.g., HR staff) are trained on the confidentiality of credential files. This training is documented in employee's training records. Signed confidentiality statements are obtained with this training and kept in employees' personnel files.

During the course of completing the responsibilities of the credentialing process, Credentialing Committee members may encounter Individually Identifiable Health Information. If this occurs, employees and committee members are required to preserve confidentiality. This is included in the confidentiality statement that is signed regarding performing as a committee member.

H. Credentialing Committee

1. Membership

CCMHS's Credentialing Committee consists of at least four (4) members appointed by the Executive Director for two-year terms. The Committee is chaired by the Senior Clinical Staff Person. Other

members include Human Resources staff, at least one provider who has no other role in management and one peer reviewer. Other providers, including specialty expertise, may be ad hoc members as needed and requested by the Senior Clinical Staff Person. When accessing an appropriate peer in order to discuss whether a particular type of provider is practicing reasonable standards of care, the clinical peer may attend the Credentialing Committee meeting in person or via telephone. The clinical peer's input will be reflected in the committee meeting minutes. All members of the Credentialing Committee will sign a confidentiality agreement and receive training regarding the confidentiality of the Committee's work before participating in a meeting of the Committee. The names of all attending will be documented in the meeting minutes.

2. Responsibilities of the Credentialing Committee

   a. To delegate the authority to approve or disapprove clean applications to the Senior Clinical Staff Person of the Committee**.**

   b. To review the credential file and application of all providers (individual and organizational) presented by the Senior Clinical Staff Person and give final approval or disapproval of the applicant for participation as a CCMHS provider.

   c. To discuss whether providers are meeting reasonable standards of care.

   d. To identify and lead the review and/or investigation of any quality of care issues discovered during the credentialing process (e.g., missing information, inconsistent information, malpractice issues, etc.). The presence of any past or current disciplinary action by the State Licensing Board, or documented by the Database, or any other regulatory authority and/or the existence of any pending malpractice suits or previous adverse malpractice judgments will be examined.

   e. To access appropriate clinical peer input when discussing standards of care for a particular type of provider.

   f. To maintain minutes of all committee meetings and to document all actions. The minutes of the meetings will protect the confidentiality of the applicants and provide sufficient detail to demonstrate a discussion was held for each applicant with issues regarding their application.

   g. To provide guidance to CCMHS staff on the overall direction of the credentialing program.

   h. To evaluate and report to CCMHS management on the effectiveness of the credentialing program.

   i. To review and approve CCMHS's credentialing and privileging policies and procedures.

   j. To meet as often as necessary to fulfill its responsibilities, but no less than quarterly.

   k. To make credentialing decisions based on multiple criteria related to professional competency, quality of care and the appropriateness by which health services are provided.

   l. To ensure discrimination does not occur, based on an individual's gender, sexual orientation, gender identity, age, race, religion, disability, ethnic origin, national origin and any other such prejudicial biases.

   m. To maintain a comprehensive list of all individual healthcare providers and review/update the list at each meeting.

3. Review of Credentials

All initial credentialing applications will be reviewed by CCMHS's Credentialing Committee within 180 days of the date of the provider signature on the attestation page. CCMHS will provide written notification of the credentialing determination within 10 days of the Senior Clinical Leader's review. An individual provider or organizational provider that is denied credentialing or re-credentialing will be provided with the reasons for the decision in writing. The provider has access to CCMHS's Appeals Process. Upon approval of the provider's credentialing application, the provider will be added to the list of providers for CCMHS.

4. Provisional Credentialing of Individual Practitioners

Provisional credentialing of providers is intended to increase the number of available providers in underserved areas. Provisional credentialing can be granted when it is in the best interest of Medicaid Beneficiaries to have providers available prior to the formal completion of the entire credentialing process. Provisional credentialing shall not exceed 150 calendar days. CCMHS will make a decision regarding provisional credentialing within 31 calendar days of receipt of the completed provider credentialing application.

For consideration of provisional credentialing, at a minimum, a provider must complete NorthCare Network's Credentialing Application and primary source verification must be completed on:

a. Licensure or certification;

b. Board certification, if applicable, or the highest level of credential attained; and

c. Medicare/Medicaid sanctions, if any.

CCMHS's Senior Clinical Staff Person will review the information obtained and determine whether or not to grant provisional credentialing for all providers. CCMHS will move the credentialing process forward as quickly as possible for providers with provisional status.

II. Re-credentialing/Continuous Credentialing Individual Practitioners

A. Formal re-credentialing for individual practitioners occurs every two years. The same procedures as for initial credentialing are applied and include:

1. Updating the standard application submitted previously (either initially or at last re-credentialing).

2. Providing a cover letter with contact information of how to communicate with credentialing staff regarding application.

B. Continuous credentialing of providers at CCMHS is an ongoing process.

1. CCMHS reviews Federal and State of Michigan information regarding individual practitioners and organizational providers who have received sanctions or limitations on licensure/ certification from various agencies as they are published or available. For continuous credentialing, CCMHS utilizes the following systems:

a. Long Term Care Workforce Background Check, which will alert CCMHS when a provider has been convicted of a crime that excludes him/her from employment at CCMHS.

b. Driver's License check.

c. Data Bank continuous query which will alert CCMHS of any adverse licensure actions, adverse finding by a State licensing or certification authority, peer review organization negative actions or findings, private accreditation organization negative actions or findings, licensing and certification actions, civil judgments (health care related), criminal convictions (health care related), exclusions from Federal or State health care programs, and other adjudicated actions or decisions (formal or official actions or omissions that affect or could affect the payment, provision, or delivery of a health care item or service).

2. The annual performance review includes a review of at least, but not necessarily limited to:

a. any corrective action taken;

b. trainings that have been completed;

c. any validated concerns (including dignity and respect) from people served;

d. provider quality issues (such as the delivery of quality healthcare through evidenced-based practices, practice guidelines and fidelity to standards of treatment);

e. adherence to standards of clinical documentation;

f. the provider's privileges;

g. driver's license.

h. ICHAT (Michigan State Police for criminal background check).

III. Credentialing/Re-credentialing Facilities and Other Organizational Providers

A. Facilities and other organizational providers must credential staff according to their accreditation and contract with CCMHS. A NorthCare Organizational Credentialing Application will be completed for initial credentialing and for re-credentialing at least every two years. This is monitored as part of site reviews.

B. Initially and at the time of contract renewal, CCMHS verifies that the organizational provider is licensed or certified as necessary to operate in Michigan and has not been excluded from Medicaid or Medicare participation relating to procurement and health care issues.

C. CCMHS conducts annual reviews of all contract providers. Included is a review of the organization's credentialing/re-credentialing policies to assure compliance with CCMHS's credentialing policy.

D. For re-credentialing, CCMHS staff will verify updated applications, review the annual site review report and submit their recommendation to CCMHS's Credentialing Committee for final approval to maintain participation in the network. Re-credentialing applications includes a process for ongoing monitoring and intervention, if appropriate, of provider sanctions, complaints and quality issues pertaining to the provider. Ongoing monitoring includes a review of:

1. Medicare/Medicaid sanctions;

2. State sanctions or limitations on licensure, registration or certification;

3. Member/client concerns which include grievance (complaints) and appeals information including dignity and respect;

4. Organizational Provider quality issues such as the delivery of quality healthcare through evidence-based treatments; practice guidelines and fidelity to standards of treatment; and abiding by agency standards of clinical documentation and other requirements.

E. If issues of quality of care emerge during the review of an application, such as missing or inconsistent information, training requirements or consumer safety or malpractice issues:

1. CCMHS staff who reviewed the application will send findings of their review to CCMHS's Credentialing Committee with a recommendation to approve or disapprove the provider's application.

2. The Senior Clinical Staff Person may request the staff who conducted the review to present the recommendation to the Credentialing Committee.

3. CCMHS's Credentialing Committee will make a decision as to whether to approve with no conditions; require a plan of correction; or, deny the request for credentialing.

F. At least every two years, CCMHS conducts a credentialing audit of contracted facilities or other organizational providers that includes a review of the security and confidentiality of credentialing records and an audit of credentialing files. The sample size of credentialing files should be 10 percent of such files. If the sample size is less than ten, all ten files will be reviewed. In no case will more than thirty (30) files be reviewed.

G. CCMHS will maintain a list of all credentialed organizational providers.

IV. Deemed Status

CCMHS may recognize and accept credentialing activities conducted by another CMHSP for any provider that delivers healthcare services to both CCMHS and the other CMHSP. In such situations, CCMHS shall maintain copies of the credentialing CMHSP's decisions in the provider's contract file.

V. Provider Directory

A. The Provider Directory includes individual practitioners at CCMHS and all contract providers and facilities. The directory is maintained by CCMHS and published on CCMHS's website. A provider is removed from the directory within five (5) days of the determination that the provider is not being re-credentialed for any reason.

B. CCMHS staff may print hard copies of the Provider Directory for people receiving services.

C. CCMHS will use the spreadsheet provided by NorthCare to submit the credentialed/re-credentialed providers to the NorthCare Credentialing Committee. NorthCare holds the final approval authority for credentialing granted by CCMHS.

1. CCMHS updates the spreadsheet when a provider or organization is credentialed or re-credentialed or any changes are made regarding any listed provider (no more than 45 days from the date of review by the Credentialing Committee).

2. The spreadsheet will be updated by NorthCare and returned to CCMHS's credentialing staff with approvals, denials and any additional information.

D. If a provider is removed from CCMHS's provider list for a sanction or incident that leads to exclusionary status, CCMHS will notify NorthCare within ten (10) business days.

VI. Reporting Requirements

A. CCMHS shall report any known improper conduct of any credentialed provider that results in suspension or termination as a provider for CCMHS to appropriate authorities (i.e., MDHHS, licensing, the Attorney General, etc.), as consistent with current Federal and State requirements, including those specified in the MDHHS Medicaid Managed Specialty Supports and Services Contract.

B. It is the responsibility of any provider to notify CCMHS of any adverse change in licensure or certification status as soon as the provider is aware of or should have been aware of the change. Acknowledgement of this responsibility is documented in the annual performance review of the provider.

C. CCMHS will notify NorthCare immediately when any providers are terminated.

VII. Removal as a Provider

In addition to termination as a result of being included on an Exclusions Database, providers may be removed under the following circumstances.

A. Expiration of Licenses

Any provider with an expired license will be removed from practice at CCMHS until the license can be verified. Any provider who has not renewed his/her license or certification within the applicable grace periods (per licensing) of its expiration will be terminated as a provider for CCMHS. Providers who are terminated for lapsed licensure or certification may reapply for participation as a provider for CCMHS at the discretion of CCMHS's Executive Director once licensure or certification is renewed.

B. Other Identified Credentialing Issues

If other credentialing issues arise (for instance, if a provider ceases to comply with credentialing criteria as determined through the processes of continuous compliance monitoring or re-credentialing or if the provider is not re-credentialed within the time frame required by CCMHS) the Senior Clinical Staff Person for the Credentialing Committee must be notified. The issues will be resolved through Committee action and/or CCMHS's disciplinary practices.

If CCMHS becomes aware of a lack of compliance to established practice standards on the part of any provider, CCMHS will reassess the provider's ability to perform the required services.

In such situations, CCMHS's Credentialing Committee will assess the information and will take action as deemed necessary. The Credentialing Committee may determine that no action is justified; recommend a letter of guidance, warning or reprimand; impose conditions for continued practice in the network; impose a requirement for monitoring or consultation; recommend additional training or education; or, determine that the provider should be terminated for cause (as in the case of a loss of license).

VIII. Appeal Process

Note: This appeals process is not available to providers when conditions result in immediate termination because of loss of required certification or licensure; listing of the provider by a State department or agency as being suspended from service participation in the Michigan Medicaid and/or Medicare programs; and/or the provider being listed by a State department or agency in its registry for Unfair Labor Practices.

If an organizational provider, group or individually licensed provider disagrees with a determination by CCMHS in the application process or during review of a provider's status, and wishes to have the matter reviewed at a higher level:

A. The provider may submit a written request and supporting documentation to CCMHS's CEO or designee within thirty (30) calendar days of disposition. The request must include the reason for the appeal and the documentation to support the appeal.

B. An appeal review will be conducted within twenty (20) calendar days of receipt of the provider request by a panel of at least three qualified individuals not involved in previous decisions relating to this appeal. At least one member will be a participating provider not involved in the day-to-day operations of network management and who is a clinical peer of the participating provider that filed the dispute.

C. After formal review of the dispute, a written summary of the outcome will be given to the provider, within fourteen (14) calendar days of completion.

D. The decision of the appeal review panel will be the final decision regarding the dispute.

E. In the event of an emergent non-compliance dispute, the appeal process will be initiated and completed within five (5) working days.

CROSS REFERENCE:

42 CFR 438.610

URAC Standards

NorthCare Delegation Agreement

Medicaid Provider Manual

Medicaid Sub-Contracting Agreement

CCMHS Policy - Background Checks

CCMHS Policy - Clinical Privileging of Individual Practitioners

CCMHS Policy - Staff Competencies

CCMHS Policy - Contracting for Clinical Services

CCMHS Policy - Excluded Parties List

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: May 26, 2021 Disclosure of Ownership, Control & Criminal Convictions.P2

RESCINDS: May 29, 2019

CATEGORY: Contracts and Credentialing

SUBJECT: Disclosure of Ownership, Control and Criminal Convictions

POLICY: As an affiliate of the NorthCare Network, it is the policy of the Copper Country Mental Health Services Board (CCMHS) and any contractors or subcontractors to not knowingly have a relationship with any individual or entity that is debarred, suspended, or otherwise excluded from participating in federal health care programs or procurement activities with a director, officer, or partner of the contractor/subcontractor; a person with beneficial ownership of 5 percent or more of the contractor/subcontractor's equity; or a network provider or person with an employment, consulting or other arrangement with the contractor/subcontractor for the provision of item and services that are significant and material to CCMHS' or the contractor's obligations under contract with the State. CCMHS, contractors, and subcontractors must comply with federal regulations to obtain, maintain, disclose, and furnish required information about ownership, control interests, business transactions, and criminal convictions as specified in 42 CFR 455.104-106. In addition, CCMHS ensures that any and all contracts and sub-contracts, agreements, purchase orders, or leases to obtain space, supplies, equipment or services provided with Medicare or Medicaid funds require compliance with 42 CFR 455.104-106. CCMHS will report criminal offenses specific in 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act; these offenses include convictions of program-related crimes, patient abuse, healthcare fraud, and controlled substances. The Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts will be notified when disclosures are made by providers with regard to those offenses as detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act.

PURPOSE: The purpose of this policy is to ensure CCMHS, contractors, and subcontractors do not have a relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in any Federal health care program or procurement activities.

DEFINITIONS:

Disclosing Entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Family Members: for the purpose of this policy include spouse, parent, child, or sibling.

Fiscal Agent: a contractor that processes or pays vendor claims on behalf of the Disclosing Entity.

Managing Employee: with respect to an entity, an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the entity, or who directly or indirectly conducts the day-to-day operations of the entity and those in a position of influence or authority.

Other Disclosing Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners)that furnishes, or arranges for the furnishing of health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Person With An Ownership Or Control Interest: with respect to an entity, a person who: (a) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceed 5 per centum of the total property and assets of the entity; or (b) is an officer or director of the entity or a partner in the entity, if the entity is organized as a corporation.

PROCEDURE:

I. Disclosures must be made regarding:

A. Ownership, controlling interest and management authority or influence in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership of 5 percent or more; including relatives.

B. Information related to business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

C. Information on persons convicted of crimes must be disclosed before entering or renewing a provider agreement or upon written request.

II. Disclosure statements will include the following required information:

A. Name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity. The address for corporate entities must include primary business address, every business location, and P.O. Box location.

B. Date of Birth and Social Security Number of each person with an ownership or control interest in the disclosing entity.

C. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has five percent or more interest.

D. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with an ownership in the disclosing entity as a family member or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has five percent or more interest, is related to another person with an ownership or control interest as a family member.

E. The name of any other disclosing entity in which the owner of the disclosing entity has an ownership or control interest.

F. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity.

G. The identity of any individual who has an ownership or control interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

III. NorthCare Network requires each contractor and subcontractor to identify their "managing employees" in policy. CCMHS' managing employees include, at minimum: Executive Director, Associate Director, Finance Director, and the Board of Directors.

IV. Any disclosing entity must furnish a disclosure statement at any of the following times:

A. When the provider submits a provider application;

B. Upon execution of the provider agreement or contract;

C. During re-credentialing or re-contracting;

D. Within 35 days of any change in the ownership of a disclosing entity.

V. NorthCare Network requires contractors (such as CCMHS) and subcontractors, through written agreements, to have processes for obtaining attestation of criminal convictions and full disclosure statements identified in 42 CFR Part 455 Subpart B and that policies and procedures for subcontracting, employment, and credentialing include requirements to report to NorthCare Network any individuals with criminal convictions described under 1128 (a) and 1128 (b)(1)(2) or (3) of the Act or individuals that have had civil monetary penalties or assessments imposed under section 1129 A of the Act.

VI. NorthCare and Network Providers such as CCMHS will conduct an OIG Exclusion database search at time of hire or contract and monthly thereafter for as long as the individual or entity is employed or under contract. The OIG database search will also be performed monthly on all disclosing entities and on any individuals with ownership or control interest identified on the disclosure form. CCMHS will communicate all OIG database search matches to NorthCare immediately; and, provide evidence of monthly searches and findings upon request and at least annually as part of the annual performance and compliance review. NorthCare Network ensures all contractors and subcontractors have a process for obtaining attestation of criminal convictions and full disclosers (identified in 42CFR Part 455 Subpart B) from managing employees; board of directors; individuals with beneficial ownership; and individuals with an employment, consulting or other arrangement with the contractor or subcontractor.

VII. CCMHS will notify NorthCare Network when disclosures are made by providers with regard to those offenses as detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Act. NorthCare Network will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts within two business days of receiving the disclosure.

VIII. Failure to fully complete the disclosure form as required or the submission of false or misleading information to NorthCare Network or to CCMHS will be subject to contractual sanctions up to and including immediate suspension of funding and termination of the contractual agreement or termination as a member of the Board(s).

CROSS REFERENCE:

N/A

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 E-mail Usage.P3

RESCINDS: April 24, 2019

CATEGORY: Information Technology

SUBJECT: E-mail Usage

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to provide to authorized staff, access to Agency e-mail facilities.

PURPOSE: To define access and use of the resource and establish guidelines for the appropriate use.

PROCEDURE:

Electronic mail (e-mail) is defined as the exchange or storage of electronic messages and files between computers that are connected to the CCMHS' network or the Internet.

I. Appropriate Use of Electronic Mail (E-Mail):

A. Individuals at CCMHS are encouraged to use e-mail to further the goals and objectives of CCMHS. The types of activities that are encouraged include:

1. Common communication with fellow employees and business partners within the context of an individual's assigned responsibilities
2. Non-treatment related communication with groups that work with persons served (e.g. Mental Health Support Group – Keweenaw Area, the Persons Served Advisory Committee, etc.)
3. Acquiring or sharing information necessary or related to the performance of an individual's assigned responsibilities
4. Participating in educational or professional development activities

B. Official CCMHS' communications may be delivered via the e-mail system. Employees with e-mail accounts are expected to check their e-mail in a consistent and timely manner so that they are aware of important announcements and updates, as well as for fulfilling business and role-oriented tasks.

C. E-mail users are responsible for mailbox management, including organization and cleaning.

D. E-mail access will be terminated when the employee leaves employment with CCMHS. CCMHS is under no obligation to store or forward the contents of an individual's e-mail inbox/outbox after the term of their employment has ceased.

E. It is the responsibility of the employee to protect the confidentiality of their account and password information.

F. Extreme caution shall be used when communicating via e-mail. E-mail messages sent outside of CCMHS becomes the property of the receiver. Do not communicate anything that you wouldn't feel comfortable being made public.

II. Sending or Receiving E-Mails Containing ePHI:

A. Receiving unsolicited e-mail messages from persons served, or their parents or guardians, containing ePHI shall be forwarded to the Records Department to be added to the record of the person served.

1. The recipient of the e-mail, if not the Primary clinician of the person served, shall notify the appropriate clinician of the incident.

a) The Primary clinician shall discuss the inappropriateness of the e-mail communication with the sender via telephone or face-to-face conversation.

2. If the recipient of the e-mail is the Primary clinician of the person served, he or she shall discuss the inappropriateness of the communication.

B. E-mail is not considered a completely secure form of communication. Therefore, unencrypted ePHI sent to non-CCMHS e-mail accounts is not permitted.

1. E-mail encryption shall be utilized for e-mails containing ePHI sent outside the CCMHS' e-mail system.

2. Additional e-mail security and encryption training is required for all employees prior to initial e-mail communication. The employee shall request this training from the HIPAA Security Officer.

C. E-mail communication between CCMHS staff members and a person served, or their parent or guardian is not permitted without a signed consent form.

D. Messages containing ePHI should be avoided. If required, provide only the minimally necessary information to the receiving party including only initials and MCO number on e-mail.

E. All professional and medical records requirements shall be adhered to. This may include, but is not limited to, one or more of the following: "need to know", confirming a release of information and documentation in the clinical chart.

III. Inappropriate Use of E-Mail:

A. Use of e-mail in any way that violates CCMHS' policies or rules.

B. Use of e-mail for illegal or unlawful purposes includes but is not limited to: Copyright infringement, obscenity, libel, slander, fraud, defamation, plagiarism, harassment, intimidation, forgery, impersonation, soliciting for illegal pyramid schemes, and computer tampering (e.g. spreading of computer viruses).

C. Inappropriate use of e-mail including but is not limited to: unsolicited mass mailings, non-CCMHS' commercial activity, political campaigning, dissemination of chain letters, and use by non-CCMHS' employees.

D. CCMHS' e-mail systems and services are not to be used for purposes that could be reasonably expected to cause excessive strain on systems, cause a breach of the confidentiality of persons served or divulge sensitive financial information.

E. Viewing, copying, altering, or deleting of e-mail accounts or files belonging to CCMHS or another individual without authorized permission.

1. Storing large files in a Lotus Notes forum and sending only a link to the forum entry is the preferred method to disseminate large files to CCMHS' employees.

F. Opening e-mail attachments from unknown or unsigned sources. Attachments are the primary source of computer viruses and should be treated with the utmost caution.

G. Sharing e-mail access with another person or attempting to obtain another person's e-mail account password. E-mail accounts are only to be used by the registered user.

H. Excessive personal use of CCMHS' e-mail resources. CCMHS allows limited personal use for communication with family and friends, and public service so long as it does not interfere with staff productivity, pre-empt any business activity, or consume more than a trivial amount of resources.

I. Independent learning and continuing education is permitted with approval from the employee's supervisor. The learning should not interfere with regular job responsibilities or productivity.

J. The use of personal email addresses for CCMHS business is prohibited unless approved in advance by the IT Department (this includes non-authorized email domains such as gmail.com, etc.).

IV. E-Mail Account Administration:

A. The e-mail systems and services are owned or operated by CCMHS, and therefore, Agency property. This gives CCMHS the right to monitor any and all e-mail traffic passing through its e-mail systems and/or communication networks.

B. Personal or business e-mail messages residing in CCMHS' e-mail system is the property of CCMHS. Access may be revoked at any time.

C. Despite end-user deletion, backup copies of e-mail messages may exist in compliance with CCMHS' disaster recovery procedures. The goals of these backup and archiving procedures are to ensure system reliability, provide evidence for investigations and prevent business data loss.

D. If it is discovered or there is reason to suspect activities that do not comply with applicable laws or Agency policies or procedures, e-mail records may be retrieved and used to document the activity in accordance with due process outlined in the CCMHS' Corrective/Progressive Discipline Policy.

V. Reporting Misuse:

A. Any allegations of misuse shall be promptly reported to the HIPAA Security Officer.

B. If you receive an offensive e-mail, do not forward, delete or reply to the message. Instead, report it directly to the HIPAA Security Officer.

VI. Sanctions for Misuse:

A. Sanctions for inappropriate use of e-mail may include, but are not limited to, one or more of the following:

1. Temporary or permanent revocation of access to some or all computing, networking or communication resources and facilities

2. Disciplinary action according to the CCMHS' Personnel Policy

3. Legal action according to applicable laws and contractual agreements

APPLICATION: This procedure applies to all staff members and includes all e-mail systems and services operated by CCMHS, all e-mail account users/holders (both temporary and permanent), and all e-mail records.

The Director of Information Technology is responsible for monitoring this procedure.

CROSS REFERENCE:

CCMHS Policy - Information Management and Access Control

CCMHS Policy - Workstation Usage and Security

CCMHS Policy - Internet Usage

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: June 28, 2017 Family Planning-Reproductive Health.P2

RESCINDS: May 28, 2014

CATEGORY: Recipient Rights

SUBJECT: Family Planning - Reproductive Health

POLICY: It is the policy of the Copper Country Mental Health Services (CCMHS) Board to safeguard the rights of recipients related to matters of reproductive health; contraception, sterilization, abortion as mandated in the Mental Health Code and Administrative Rules.

Family planning, reproductive health services shall be between the recipient, parent of minor child, or guardian legally empowered to consent to such measures, and the recipient's physician.

PURPOSE: To establish policies and procedures prescribing the manner in which staff may provide information to recipients who request information on matters concerning family planning, reproductive health.

PROCEDURE:

I. The availability of family planning and reproductive health information services shall be made known to recipients of services, their guardians and to parents of minor recipients by the CCMHS staff in charge of the recipient's written plan of service.

II. It shall be made known to any such person that receiving mental health services does not depend in any way on requesting or not requesting reproductive health information services or family planning services and is in no way dependent upon a decision to act on the family planning information. The notice shall be documented in the clinical record.

III. Upon request of any such person, CCMH staff will provide or arrange for the provision of education and information on family planning and reproductive health.

IV. Staff may assist in arrangements to secure family planning services if the recipient has voluntarily requested them and one of the following has given written informed consent.

A. The recipient is 18 years of age or over and competent to consent.

B. A guardian legally empowered to consent to such measures.

C. The Probate Court.

D. A parent if the recipient is less than 18 years of age.

CROSS REFERENCE:

Michigan Department of Health and Human Services Administrative Rule 330.7029.

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: April 24, 2019 Freedom of Movement.P4

RESCINDS: May 30, 2018

CATEGORY: Recipient Rights

SUBJECT: Freedom of Movement

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that recipients of services be placed in the least restrictive setting and that the freedom of movement of a recipient of services shall not be limited more than is necessary to provide the recipient mental health services, to prevent injury to the recipient or others, or to prevent substantial property damage.

PURPOSE: The purpose of this procedure is to ensure that recipients of services are placed in the least restrictive setting of their choosing and have access to all areas within the home, on the grounds, in the community, and in the Agency Program areas that are for recreational, vocational, and normal social activities.

PROCEDURE:

I. Limitations of freedom of movement shall only be implemented for health and safety reasons.

II. As required by the Home and Community Based Services Final Rule (HCBS) and Mental Health Code, any effort to limit freedom of movement must be:

1. Justified by a specific and individualized assessed health or safety need;
2. The minimum limitation necessary to address the need;
3. Addressed through the PCP process;
4. Determined with the participation of the recipient and the recipient's family, if at all possible;
5. Fully explained to the recipient and the recipient's family by the client service manager before implementing the limitation;
6. Approved by the Behavior Treatment Committee;
7. Removed when the circumstance that justified its adoption ceases to exist; and is
8. Subject to appeal by the resident or another person on the resident's behalf by filing a Recipient Rights complaint.

The following requirements must be documented in the IPOS when a specific health or safety need warrants such a limitation:

1. The specific and individualized assessed health or safety need.
2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs.

3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.
4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.
5. A regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. The date of expiration.
8. Informed consent of the person to the proposed modification.
9. Assurance that the modification itself will not cause harm to the person.

III. The appropriateness of the recipient's placement in Residential Programs shall be reviewed by the Treatment Team on a regular basis.

CROSS REFERENCE:

Mental Health Code

Home and Community Based Services Final Rule

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: May 31, 2023 Grievance & Appeal Processes.P11

RESCINDS: May 27, 2020

CATEGORY: Recipient Rights

SUBJECT: Grievance & Appeal Processes

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS), hereafter referred to as Community Mental Health Services Provider (CMHSP), that all recipients have the right to a fair and efficient process for resolving disputes regarding their services and supports managed and/or delivered by CMHSP and its provider network. A recipient of, or applicant for, public mental health services have various avenues available to pursue the resolution of disputes. Recipients will receive notice of their rights, information about the grievance and appeal process, and be assisted, as necessary or requested, in achieving resolution of service delivery disputes.

PURPOSE: The purpose of this policy is to outline the grievance and appeals processes for Medicaid recipients, **including Healthy Michigan recipients**, of CMHSP or through its provider network, in order to promote the resolution of recipient concerns, and support and enhance the overall goal of improving the quality of care.

DEFINITIONS:

The following terms and definitions are utilized in this policy.

Adverse Benefit Determination: A decision that adversely impacts a Medicaid recipient's claim for services due to:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- Reduction, suspension, or termination of a previously authorized service.
- Denial, in whole or in part, of payment for a service.
- Failure to make a standard Service Authorization decision and provide notice about the decision within **14 calendar days** from the date of receipt of a standard request for service.
- Failure to make an expedited Service Authorization decision within **72 hours** after receipt of a request for expedited Service Authorization.
- Failure to provide services within **14 calendar days** of the start date agreed upon during the person-centered planning and as authorized by the CMHSP.
- Failure of the CMHSP to resolve standard Appeals and provide notice within **30 calendar days** from the date of a request for a standard appeal.
- Failure of the CMHSP to resolve expedited Appeals and provide notice within **72 hours** from the date of a request for an expedited appeal.
- Failure of the CMHSP to resolve Grievances and provide notice within **90 calendar days** of the date of the request.

Adequate Notice of Adverse Benefit Determination: Written statement advising the recipient of a decision to deny or limit authorization of Medicaid services requested, which notice must be provided to the Medicaid recipient **on the same date** the Adverse Benefit Determination takes effect.

Advance Notice of Adverse Benefit Determination: Written statement advising the recipient of a decision to reduce, suspend or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid recipient at least **10 calendar days prior** to the proposed date the Adverse Benefit Determination is to take effect.

Appeal: A review at the local level by a CMHSP of an Adverse Benefit Determination, as defined above, presided over by individuals not involved in the decision-making or previous level of review.

Authorization of Services: The processing of requests for initial and continuing service delivery.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by a recipient or the recipient's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the recipient's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the recipient requests the expedited review, the CMHSP determines if the request is warranted. If the recipient's provider makes the request, or supports the recipient's request, the CMHSP must grant the request.

Grievance: Recipient's expression of dissatisfaction about CMHSP service issues, other than an Adverse Benefit Determination**.** Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the recipient, failure to respect the recipient's rights regardless of whether remedial action is requested, or a recipient's dispute regarding an extension of time proposed by the CMHSP to make a service authorized decision.

Grievance Process: Impartial local level review of a recipient's Grievance**.**

Grievance and Appeal System: The processes the CMHSP implements to handle Appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them.

Hearings Coordinator: CMHSP staff or his/her designee appointed by the Executive Director to coordinate the Administrative Hearing process.

Medicaid Services: Services provided to a recipient under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Mi Health Link: Mi Health Link (MHL) is a health care option for Michigan adults, ages 21 or over, who are enrolled in both Medicare and Medicaid and live in one of the four pilot regions of Michigan, including the Upper Peninsula. The Local health plan responsible for managing the MI Health Link program is Upper Peninsula Health Plan.

Notice of Resolution: Written statement of the CMHSP of the resolution of a Grievance or Appeal.

Recipient: A person who has been determined eligible for Medicaid and who is receiving or may qualify to receive Medicaid services through CCMHS or a provider that is under contract with CCMHS.

Recipient Rights Complaint: Written or verbal statement by a recipient, or anyone acting on behalf of the recipient, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Authorization: CMHSP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration, or scope **less** than requested, as required under applicable law.

State Fair Hearing: Impartial state level review of a Medicaid recipient's appeal of an Adverse Benefit Determination presided over by a MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing".

I. GRIEVANCE AND APPEAL SYSTEM GENERAL REQUIREMENTS

Federal regulation requires the State to ensure through its contracts with PIHPs/CMHSPs, that each CMHSP has a Grievance and Appeal system in place for recipients.

The Grievance and Appeal System must provide recipients:

- An Appeal process (one level, only) which enables recipients to challenge Adverse Benefit Determinations made by the CMHSP or its agents.
- A Grievance Process.
- The right to **concurrently** file an Appeal of an Adverse Benefit Determination and a Grievance regarding other service complaints.
- Access to the State Fair Hearing process to further appeal an Adverse Benefit Determination, after receiving notice that the Adverse Benefit Determination has been upheld by the CMHSP level Appeal.
- Information that if the CMHSP fails to adhere to notice and timing requirements as outlined in CMHSP Appeal Process, the recipient is deemed to have exhausted the CMHSP's Appeals process. The recipient may initiate a State Fair Hearing.
- The right to request, and have, Medicaid covered benefits continued while a local CMHSP Appeal or State Fair Hearing is pending.
- With the written consent from the recipient, the right to have a provider or other authorized representative, acting on the recipient's behalf, file an Appeal or Grievance to the CMHSP, or request a State Fair Hearing. The provider may file an Appeal or Grievance or request a State Fair Hearing on behalf of the recipient since the State permits the provider to act as the recipient's authorized representative in doing so. Punitive action may not be taken by the CMHSP against a provider who acts on the recipient's behalf with the recipient's written consent to do so.

II. NOTICE OF ADVERSE BENEFIT DETERMINATION

A CMHSP is required to provide timely and "adequate" notice of any Adverse Benefit Determination.

A. Content & Format: The notice of Adverse Benefit Determination must meet the following requirements:

1. Recipient notice must be in writing, in a "…manner and format that may be easily understood and is readily accessible by such recipients and potential recipients," and meet the needs of those with limited English proficiency and or limited reading proficiency;

2. Notification that provides the basic legal authority for an agency to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures;

3. Description of Adverse Benefit Determination;

4. The reason(s) for the Adverse Benefit Determination, and policy/authority relied upon in making the determination;

5. Notification of the right of the recipient to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the recipient's Adverse Benefit Determination (including medical necessity criteria, any processes, strategies, or evidentiary standards used in setting coverage limits);

6. Notification of the recipient's right to request an Appeal, including information on exhausting the CMHSP's single local appeal process, and the right to request a State Fair Hearing thereafter;

7. Description of the circumstances under which an Appeal can be expedited, and how to request an Expedited Appeal;

8. Notification of the recipient's right to have benefits continued pending resolution of the Appeal, instructions on how to request benefit continuation, and a description of the circumstances (consistent with State policy) under which the recipient may be required to pay the costs of the continued services (only required when providing "Advance Notice of Adverse Benefit Determination";

9. Description of the procedures that the recipient is required to follow in order to exercise any of these rights; and

10. An explanation that the recipient may represent him/herself or use legal counsel, a relative, a friend or other spokesman.

11. The state-developed notice of an Adverse Benefit Determination template must be used by each network provider. Templates are included in MDHHS/PIHP Medicaid Managed Specialty Support and Services Contract Attachment P6.3.1.1. "Grievance and Appeal Technical Requirements PIHP Grievance System for Medicaid Beneficiaries.

B. Timing of Notice:

   1. Adequate Notice of Adverse Benefit Determination:

      a. For a denial of payment for services requested (not currently provided), notice must be provided to the recipient at the time of the Adverse Benefit Determination affecting the claim.

      b. For a Service Authorization decision that denies or limits services, notice must be provided to the recipient within **14-days** following receipt of the request for service for standard authorization decisions, or within **72-hours** after receipt of a request for an expedited authorization decision.

      c. For Service Authorization decisions not reached within **14-days** for standard request, or **72-hours** for an expedited request, (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.

         NOTE: However, the CMHSP may be able to extend the standard Service Authorization timeframe in certain circumstances. If so, the CMHSP must:

         i. make reasonable efforts to give the Enrollee prompt oral notice of the delay.

         ii. provide the recipient written notice of the reason for the decision to extend the timeframe and inform the recipient of the right to file a Grievance if he or she disagrees with that decision; and

         iii. issue and carry out its determination as expeditiously as the recipient's health condition requires and no later than the date the extension expires.

   2. Advance Notice of Adverse Benefit Determination:

      a. Required for reductions, suspensions, or terminations of previously authorized/ currently provided Medicaid Services.

      b. Must be provided to the recipient at least **10 calendar days** prior to the proposed effective date.

      c. Limited Exceptions: The CMHSP may mail an adequate notice of Adverse Benefit Determination, not later than the date of the Adverse Benefit Determination to terminate, suspend

or reduce previously authorized services, IF:

i. The CMHSP has factual information confirming the death of a recipient;

ii. The CMHSP receives a clear written statement signed by a recipient that he no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the recipient understands that this must be the result of supplying that information;

iii. The recipient has been admitted to an institution where he is ineligible under the plan for further services;

iv. The recipient's whereabouts are unknown, and the post office returns agency mail directed to him indicating no forwarding address;

v. The CMHSP establishes that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

vi. A change in the level of medical care is prescribed by the recipient's physician;

vii. The notice involves an adverse determination made with regard to the preadmission screening requirements;

viii. The date of the Adverse Benefit Determination will occur **in less than 10 calendar days.**

ix. The CMHSP has facts (preferably verified through secondary sources) indicating that action should be taken because of probable fraud by the recipient (in this case, the CMHSP may **shorten** the period of advance notice **to 5 days before** the date of the Adverse Benefit Determination).

C. Required Recipients of Notice of Adverse Benefit Determination:

1. The recipient must be provided written notice.

2. The requesting provider must be provided notice of any decision by the CMHSP to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. Notice to the provider does NOT need to be in writing.

3. If the utilization review function is not performed within an identified organization, program or unit (access centers, prior authorization unit, or continued stay units), any decision to deny, suspend, reduce, or terminate a service occurring outside of the person-centered planning process still constitutes an Adverse Benefit Determination, and requires a written notice of Adverse Benefit Determination.

III. MEDICAID SERVICES CONTINUATION OR REINSTATEMENT

A. If an Appeal involves the termination, suspension, or reduction of previously authorized services that were ordered by an authorized provider, the CMHSP MUST continue the recipient's benefits if all the following occur:

1. The recipient files the request for Appeal timely (within **60 calendar days** from the date on the Adverse Benefit Determination Notice);

2. The recipient files the request for continuation of benefits timely (on or before the latter of (i) **10 calendar days** from the date of the notice of Adverse Benefit Determination, or (ii) the intended effective date of the proposed Adverse Benefit Determination) and

3. The period covered by the original authorization has not expired.

B. Duration of Continued or Reinstated Benefits: If the CMHSP continues or reinstates the recipient's benefits, at the recipient's request, while the Appeal or State Fair Hearing is pending, the CMHSP must continue the benefits until one of following occurs:

1. The recipient withdraws the Appeal or request for State Fair Hearing;
2. The recipient fails to request a State Fair Hearing and continuation of benefits within **10 calendar days** after CMHSP sends the recipient notice of an adverse resolution to the recipient's Appeal;
3. A State Fair Hearing office issues a decision adverse to the recipient.

C. If the final resolution of the Appeal or State Fair Hearing upholds the CMHSP's Adverse Benefit Determination, the CMHSP may, consistent with the State's usual policy on recoveries and as specified in the CMHSP's contract, recover the cost of services furnished to the recipient while the Appeal and State Fair Hearing was pending, to the extent that they were furnished solely because of these requirements.

D. If the recipient's services were reduced, terminated, or suspended without an advance notice, the CMHSP must reinstate services to the level before the action.

E. If the CMHSP, or the MDHHS fair hearing administrative law judge, reverses a decision to deny authorization of services, and the recipient received the disputed services while the Appeal was pending, the CMHSP or the State must pay for those services in accordance with State policy and regulations.

F. If the CMHSP, or the MDHHS fair hearing administrative law judge, reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CMHSP must authorize or provide the disputed services promptly, and as expeditiously as the recipient's health condition requires, but no later than **72 hours** from the date it receives notice reversing the determination.

IV. SERVICE DISPUTE OPTIONS PROCESSES

When a Medicaid recipient disagrees with a Service Authorization decision or their services are not provided within the required timeframe, the Medicaid recipient may Appeal that decision or delay using various avenues of dispute processes; however, must exhaust the local dispute processes before they may request a State Fair Hearing. A Medicaid recipient may use the following processes to Appeal a Service Authorization decision or delay of services.

A. Denial of Hospitalization

1. Request for Second Opinion

a. If a preadmission screening unit or children's diagnostic and treatment service of a CMHSP denies hospitalization, the recipient, his/her guardian or his/her parent in the case of a minor child, may request a Second Opinion from the Executive Director of the CMHSP.

b. The Executive Director shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within **3 days**, excluding Sundays and legal holidays, after the Executive Director receives the request. If the determination of the second opinion is different from the determination of the preadmission screening unit, the Executive Director, in conjunction with the Medical Director, shall make a decision based on all clinical information available within **1 business day.**

c. The Executive Director's decision shall be confirmed in writing to the recipient who requested the second opinion, and the confirming document shall include the signatures of the Executive Director and Medical Director or verification that the decision was made in conjunction with the Medical Director.

d. If a recipient is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide appropriate referral services.

2. Rights Complaint

a. If the request for a Second Opinion is denied, the recipient or someone on his/her behalf may file a recipient rights complaint with the recipient Rights Office of CMHSP.

b. If the initial request for inpatient admission is denied and the recipient is a current recipient of other CMHSP services, the recipient or someone on his/her behalf is informed that they may file a Recipient Rights Complaint with the Recipient Rights Office alleging a violation of his/her right to treatment suited to condition.

c. If the Second Opinion determines the recipient is not clinically suited for hospitalization and the recipient is a current recipient of other CMHSP services, and a recipient rights complaint has not been filed previously on behalf of the recipient, the recipient or someone on his/her behalf may file a complaint with the Recipient Rights Office of CMHSP.

3. Local Appeal - **See Local Appeal Process section.**

4. State Level - **See State Fair Hearing Appeal Process section.**

B. Denial of Access to Community Mental Health Program Services

If an initial applicant for CMHSP services is denied such services, an appropriate referral may be provided.

1. Request for Second Opinion

a. If an initial applicant for CMHSP services is denied such services, the applicant or his/her guardian, or the applicant's parent in the case of a minor, must be informed of their right to request a Second Opinion of the Executive Director or designee. The request shall be processed in compliance with Section 705 of the Michigan Mental Health Code and must be resolved **within 5 business days**.

i. The Executive director or designee shall secure the Second Opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist.

ii. If the individual providing the Second Opinion determines that the applicant has a serious mental illness, serious emotional disturbance, or an intellectual/developmental disability, or is experiencing an emergency situation or urgent situation, the community mental health services program shall direct services to the applicant.

2. Rights Complaint

a. The applicant or his/her guardian may **not** file a recipient rights complaint for denial of services suited to condition, as he/she does not have standing as a recipient of mental health services. The applicant or his/her guardian may, however, file a rights complaint if the request for a Second Opinion is denied.

3. Local Appeal - **See Local Appeal Process section**.

4. State Level - **See State Fair Hearing Appeal Process section.**

C. Denial of Service

Denial through the Service Authorization process of the request for Medicaid state plan, waiver, or additional mental health service **OR** denial of the requested amount, scope or duration of a service that was identified and agreed upon by the recipient during person-centered planning process.

1. Rights Complaint

   The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

2. Local Appeal - **See Local Appeal Process section**.

3. State Level - **See State Fair Hearing Appeal Process section**.

D. Suspension, Reduction, or Termination of a Currently Provided Service.

1. Rights Complaint

   The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

2. Local Appeal - **See Local Appeal Process section.**

3. State Level - **See State Fair Hearing Appeal Process section.**

E. Unreasonable Delay of Services

Unreasonable delay of a service beyond the start date agreed upon during the person-centered planning process and as authorized by the CMHSP. Unreasonable delay is defined as **14 or more calendar days**.

1. Rights Complaint

   The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

2. Local Appeal - **See Local Appeal Process section.**

3. State Level - **See State Fair Hearing Appeal Process section.**

F. Dissatisfaction with Program, Provider, Other

Dissatisfaction about any matter relative to a service other than an action as described above.

1. Grievance - **See Grievance Local Process**

2. Rights Complaint

If a complaint alleges a violation of a Mental Health Code protected right.

V. GRIEVANCE PROCESS

A. Federal regulations provide recipients the right to a Grievance process to seek resolution to issues that are not Adverse Benefit Determinations.

B. Generally:

1. Recipients must file Grievances with the CMHSP organizational unit approved and administratively responsible for facilitating resolution of Grievances.

2. Grievances may be filed at any time by the recipient, guardian, or parent of a minor child or his/her legal representative.

3. Recipient's access to the State Fair Hearing process respecting Grievances is only available when the CMHSP fails to resolve the Grievance and provide resolution within **90 calendar days** of the date of

the request. This constitutes an "Adverse Benefit Determination" and can be appealed to the MDHHS Administrative Tribunal using the State Fair Hearing process.

C. CMHSP Responsibility when Recipient Files a Grievance:

1. Provide recipients reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
2. Acknowledge receipt of the Grievance.
3. Maintain a record of Grievances for review by the State as part of its quality strategy.
4. Submit the written Grievance to appropriate staff including a CMHSP administrator with the authority to require corrective action, none of who shall have been involved in the initial determination.
5. Ensure that the individual(s) who make the decisions on the Grievance:
   a. Were not involved in any previous level review or decision-making, nor a subordinate of any such individual.
   b. When the Grievance involves either (i) clinical issues, or (ii) denial of expedited resolution of an Appeal, are individual(s) who have appropriate clinical expertise, as determined by the State, in treating the Recipient's condition or disease.
   c. Take into account all comments, documents, records, and other information submitted by the recipient or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

D. Grievance Resolution Timing and Notice Requirements

1. Timing of Grievance Resolution: Provide the recipient a written notice of resolution not to exceed **90 calendar days** from the day the CMHSP received the Grievance.
2. Format and Content of Notice of Grievance Resolution:
   a. Recipient notice of Grievance resolution must meet the requirements "…in a manner and format that may be easily understood and is readily accessible by such recipients and potential recipients," and meet the needs of those with limited English proficiency and or limited reading proficiency.
   b. The notice of Grievance resolution must include:
      i. The results of the Grievance process;
      ii. The date the Grievance process was concluded;
      iii. Notice of the recipient's right to request a State Fair Hearing, if the notice of resolution is more than **90-days** from the date of the Grievance; and
      iv. Instructions on how to access the State Fair Hearing process, if applicable.

VI. LOCAL APPEAL PROCESS (CMHSP)

A. Upon receipt of an Adverse Benefit Determination notification, federal regulations provide recipients the right to appeal the determination through an internal review by the CMHSP. Each CMHSP may only have one level of Appeal. Recipients may request an internal review by the CMHSP, which is

the first of two Appeal Levels, under the following conditions:

1. The recipient has **60 calendar days** from the date of the notice of Adverse Benefit Determination to request an Appeal.

2. The recipient may request an Appeal either orally or in writing. Unless the recipient requests and expedited resolution, an oral request for Appeal must be followed by a written, signed request for Appeal.

   NOTE: Oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).

3. In the circumstances described above under the Section entitled "Continuation of Benefits," the CMHSP will be required to continue/reinstate Medicaid Services until one of the events described in that section occurs.

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B. CMHSP Responsibilities when Recipient Requests an Appeal:

1. Provide recipients reasonable assistance to complete forms and to take other procedural steps. This includes but is not limited to auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

2. Acknowledge receipt of each Appeal.

3. Maintain a record of appeals for review by the State as part of its quality strategy.

4. Ensure that the individual(s) who make the decisions on Appeals:

   a. Were not involved in any previous level of review or decision- making, nor a subordinate of any such individual;

   b. When deciding an Appeal that involves either (i) clinical issues, or (ii) a denial based on lack of medical necessity, are individual(s) who have the appropriate clinical expertise, as determined by the State, in treating the recipient's condition or disease; and

   c. Take into account all comments, documents, records, and other information submitted by the recipient or their representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

5. Provide the recipient a reasonable opportunity to present evidence, testimony and allegations of fact or law in person and in writing and inform the recipient of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals;

6. Provide the recipient and his/her representative the recipient's case file, including medical records and any other documents or records considered, relied upon, or generated by or at the direction of the CMHSP in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

7. Provide opportunity to include, as parties to the Appeal, the recipient and his or her representative, or the legal representative of a deceased recipient's estate;

8. Provide the recipient with information regarding the right to request a State Fair Hearing and the process to be used to request one.

C. Appeal Resolution Timing and Notice Requirements:

1. Standard Appeal Resolution (timing): The CMHSP must resolve the Appeal and provide notice of resolution to the affected parties as expeditiously as the recipient's health condition requires, but not to exceed **30 calendar days** from the day the CMHSP receives the Appeal.

2. Expedited Appeal Resolution (timing):

   a. Available where the CMHSP determines (for a request from the recipient) or the provider indicates (in making a request on the recipient's behalf or supporting the recipient's request) that the time for a standard resolution could seriously jeopardize the recipient's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

   b. The CMHSP may not take punitive action against a provider who requests an expedited resolution or supports a recipient's appeal.

   c. If a request for expedited resolution is denied, the CMHSP must:

      i. Transfer the Appeal to the timeframe for standard resolution.

      ii. Make reasonable efforts to give the recipient prompt oral notice of the denial.

      iii. Within **2 calendar days**, give the recipient written notice of the reason for the decision to extend the timeframe and inform the recipient of the right to file a Grievance if they disagree with the decision**.**

      iv. Resolve the Appeal as expeditiously as the recipient's health condition requires but not to exceed **30 calendar days**.

   d. If a request for expedited resolution is granted, the CMHSP must resolve the Appeal and provide notice of resolution to the affected parties no longer than **72-hours** after the CMHSP receives the request for expedited resolution of the Appeal.

3. Extension of Timeframes: The CMHSP may extend the resolution and notice timeframe by up to **14 calendar days** if the recipient requests an extension, or if the CMHSP shows to the satisfaction of the State that there is a need for additional information and how the delay is in the recipient's interest.

   a. If the CMHSP extends resolution/notice timeframes, it must complete all of the following:

      i. Make reasonable efforts to give the recipient prompt oral notice of the delay; and document into the ELMER Grievance & Appeals module.

      ii. Within **2-calendar days**, give the recipient written notice of the reason for the decision to extend the timeframe and inform the recipient of the right to file a Grievance if they disagree with the decision.

      iii. Resolve the Appeal as expeditiously as the recipient's health condition requires and not later than the date the extension expires.

4. Appeal Resolution Notice Format:

   a. The CMHSP must provide recipients with written notice of the resolution of their Appeal and must also make reasonable efforts to provide oral notice in the case of an expedited resolution.

   b. Specifically, 42 CFR 438.416 indicates the State must require the CMHSP maintain records with (at minimum) the following information:

      (1) A general description of the reason for the Appeal or Grievance.

(2) The date received.

(3) The date of each review or, if applicable, review meeting.

(4) Resolution at each level of the Appeal or Grievance if applicable.

(5) Date of resolution at each level, if applicable.

(6) Name of the covered person for whom the Appeal or Grievance was filed.

(7) The Resolution Notice format must include specific elements that are built into the ELMER Grievance & Appeals module and are based on templates provided and required by MDHHS.

Further this recordkeeping must be "accurately maintained in a manner accessible to the state and available upon request to CMS."

c. Recipient notice must meet the requirements "…in a manner and format that may be easily understood and is readily accessible by such recipients and potential recipients," and meet the needs of those with limited English proficiency and or limited reading proficiency.

5. Appeal Resolution Notice Content:

a. The notice of resolution must include the results of the resolution and the date it was completed.

b. When the Appeal is not resolved wholly in favor of the recipient, the notice of resolution must also include notice of the recipient's:

i. Right to request a State Fair Hearing, and how to do so;

ii. Right to request to receive benefits while the State Fair Hearing is pending, and how to make the request;

iii. Potential liability for the cost of those benefits if the hearing decision upholds the CMHSP's Adverse Benefit Determination; and

iv. The Resolution Notice content must include specific elements that are built into the ELMER Grievance & Appeals module and are based on templates provided and required by MDHHS.

VII. STATE FAIR HEARING APPEAL PROCESS

A. Federal regulations provide a recipient the right to an impartial review by a State level administrative law judge (a State Fair Hearing), of an action of a local agency or its agent, in certain circumstances:

1. After receiving notice that the CMHSP is, after Appeal, upholding an Adverse Benefit Determination.

2. When the CMHSP fails to adhere to the notice and timing requirements for resolution of Grievances and Appeals.

B. The State may offer or arrange for an external medical review in connection with the State Fair Hearing, if certain conditions are met (e.g., it must be optional to the recipient, free to recipient, independent of State and CMHSP, and not extend any timeframes or disrupt continuation of benefits).

C. The CMHSP may not limit or interfere with a recipient's freedom to make a request for a State Fair Hearing.

D. Recipients are given **120 calendar days** from the date of the applicable notice of resolution to file a

request for a State Fair Hearing.

E. The CMHSP is required to continue benefits, if the conditions described in Section IV, "MEDICAID SERVICES CONTINUATION OR REINSTATEMENT" are satisfied, and for the durations described therein.

F. If the recipient's services were reduced, terminated, or suspended without advance notice, the CMHSP must reinstate services to the level before the Adverse Benefit Determination.

G. The parties to the State Fair Hearing include the CMHSP, the recipient and his or her representative, or the representative of a deceased recipient's estate. A Recipients Rights Officer shall not be appointed as Hearings Officer due to the inherent conflict of roles and responsibilities.

H. Expedited hearings are available.

Detailed information and instructions for the Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing process can be found on the MDHHS website at:

- www.Michigan.gov/mdhhs>>Assistance Programs>>Medicaid>>Medicaid or
- Department of Licensing and Regulatory Affairs Michigan Administrative Hearing System Fair Hearing http://www.michigan.gov/lara

VIII. RECORDKEEPING REQUIREMENTS

The CMHSP is required to maintain records of recipient Appeals and Grievances, which will be reviewed by the CMHSP as part of its ongoing monitoring procedures, as well as by State staff as part of the State's quality strategy.

A CMHSP's record of each Grievance or Appeal must contain, at a minimum:

A. A general description of the reason for the Grievance or Appeal;

B. The date received;

C. The date of each review, or if applicable, the review meeting;

D. The resolution at each level of the Appeal or Grievance, if applicable;

E. The date of the resolution at each level, if applicable;

F. Name of the covered person for whom the Grievance or Appeal was filed

G. Letter templates, as well as the Adverse Benefit Determination notice, are designed and available in ELMER and must be utilized;

H. CMHSPs must provide written notice of resolution in a format and language that, at minimum, meets the standard described in accordance with 42 CFR 438.10;

I. Grievance and appeal records must be retained for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

CMHSPs must maintain such records accurately and in a manner accessible to the State and available upon request to CMS.

IX. RECIPIENT RIGHTS COMPLAINT PROCESS

Recipients of Mental Health Services have rights to file recipient rights complaints under the authority of the State Mental Health Code. (See "Rights System" policy)

CROSS REFERENCE:

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 18 Attachment P.6.3.1.1 Amendment #1

Michigan Mental Health Code, Chapters 7, 7A, 4 and 4A

42CFR 431.200 et seq.

42 CFR 438.400 et seq.

CCMHS Policy – Rights System

CCMHS Clinical Guideline - Adequate Notice for Consumers with Medicaid, HM, or MHL

CCMHS Clinical Guideline – Advance Notice for Consumers with Medicaid, HM, or MHL

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: September 29, 2021 Grievance & Appeal Processes–Non-Medicaid.P8

RESCINDS: June 28, 2017

CATEGORY: Recipient Rights

SUBJECT: Grievance & Appeal Processes - Non-Medicaid

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS), hereafter referred to as Community Mental Health Services Provider (CMHSP), that all recipients have the right to a fair and efficient process for resolving disputes regarding their services and supports managed and/or delivered by CMHSP and its provider network. A recipient of, or applicant for, public mental health services may access several options simultaneously to pursue the resolution of disputes. Consumers will receive notice of their rights, information about the grievance and appeal process, and be assisted, as necessary or requested, in achieving resolution of service delivery disputes.

PURPOSE: The purpose of this policy is to outline the grievance and appeals processes for non-Medicaid recipients of services provided by CMHSP or through its provider network, in order to promote the resolution of recipient concerns, and support and enhance the overall goal of improving the quality of care.

DEFINITIONS:

Action (Adverse Action): A decision that adversely impacts a recipient's claim for services due to:

A. Denial or limited authorization of a requested service;

B. Reduction, suspension, or termination of a currently provided service, outside the person-centered planning process;

C. Failure to make an authorization decision and provide notice about the decision within standard time frames;

D. Failure to provide services within standard time frame.

Adequate Notice: A written notice, mailed or directly provided, to a recipient or his/her guardian or legal representative at the time a request for services is denied or at the time of signing of the individual plan of services/supports.

Advance Notice: A written notice that is provided to the recipient or his/her guardian or legal representative prior to the action, when a service, currently being provided, is reduced, suspended or terminated.

Appeal: A request for a review of an action (as defined above) relative to a service.

Authorized Representative: Whomever the recipient selects to represent them during the Grievance and Appeal process.

Grievance: An expression of dissatisfaction about any matter relative to a service, other than an action, as defined above.

Hearings Coordinator: Person or his/her designee appointed by the Executive Director to coordinate the Local Hearing process.

Michigan Department of Health and Human Services Alternative Dispute Resolution Process: An impartial review, conducted by a MDHHS representative, regarding a decision by the CMHSP to deny, terminate, reduce or suspend a non-Medicaid recipient's service.

Resolution Notice: Notice to the recipient that is required to be provided within established time frames relative to the disposition of disputes, complaints and grievances, and resolution of the disputes, complaints and grievances.

Rights Complaint: A written or verbal statement by a recipient or anyone acting on behalf of a recipient alleging a violation of a Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Utilization Review: A process, in addition to the person-centered plan, in which established criteria are used to recommend or evaluate services provided in terms of cost-effectiveness, necessity and effective use of resources.

PROCEDURES:

I. Notification of the Grievance and Appeal Process

All recipients of, or applicants for, public mental health services shall be informed of the grievance and appeals process and their right to access the process, including their ability to express dissatisfaction at any point in services. CMHSP staff shall assist individuals with grievances and/or appeals. Individuals will be provided assistance in completing forms and taking procedural steps as necessary and/or requested. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

II. Notice Requirements

A. Notice is given whenever a service is denied, reduced, suspended or terminated. This notice must be in writing and must be provided in the language format needed by the individual to understand the content (i.e., the format meets the needs of those with limited English proficiency, and/or limited reading proficiency.)

B. The written notice must contain the following:

1. A statement of what action the CMHSP intends to take;
2. The reasons for the intended action;
3. The date of the intended action;
4. The specific justification for the intended action;
5. An explanation of the Local Dispute Resolution Process.
6. If access to services or hospitalization is denied, the right to request a second opinion and an explanation of the process.
7. The recipient's right to file an appeal, grievance, and/or rights complaint and the time frames for doing so.
8. The procedures for exercising the resolution options.

9. The circumstances under which expedited resolution is available and how to request it.

C. Adequate Notice

1. During the person-centered planning process, adequate notice will be provided at the time the individual plan of service, developed or modified through a person-centered planning process, is finalized with the recipient or his/her guardian or authorized representative.

2. Denial of Service Outside the PCP Process

When an individual is denied initial access to services, or denied access to inpatient psychiatric hospitalization, the individual will be informed of this denial with the Denial of Service form. The form may be presented directly or mailed to the individual or his/her guardian or authorized representative at the time of denial. A non-Medicaid recipient may file an appeal pursuant to the Local Appeal Resolution Process described below.

D. Advance Notice

Whenever a currently authorized service or support are to be suspended, reduced, or terminated by the CMHSP or its provider network provider, (whether through a Utilization Review (UR) function or when the action is taken outside the person-centered planning process when the CMHSP does not have an identifiable UR unit), the CMHSP must inform the recipient with written notification of the change **at least thirty (30) days** prior to the effective date of action.

If a recipient's physician decides that a particular mental health service is not needed, an Advance Notice is not required.

III. Grievance and Appeal Resolution Processes

An individual receiving mental health services may pursue appeals or grievances using the following processes.

A. Denial of Hospitalization

1. Request a second opinion

a. If a preadmission screening unit or children's diagnostic and treatment service of a CMHSP denies hospitalization, the individual, his/her guardian or his/her parent in the case of a minor child, may request a second opinion from the Executive Director of the CMHSP.

b. The Executive Director shall arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within three (3) days, excluding Sundays and legal holidays, after the Executive Director receives the request. If the determination of the second opinion is different from the determination of the preadmission screening unit, the Executive Director, in conjunction with the Medical Director, shall make a decision based on all clinical information available within one (1) business day.

c. The Executive Director's decision shall be confirmed in writing to the individual who requested the second opinion, and the confirming document shall include the signatures of the Executive Director and Medical Director or verification that the decision was made in conjunction with the Medical Director.

d. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide appropriate referral services.

2. File a Rights Complaint

a. If the request for a second opinion is denied, the individual or someone on his/her behalf may file a recipient rights complaint with the Recipient Rights Office of CMHSP.

b. If the initial request for inpatient admission is denied and the individual is a current recipient of other CMHSP services, the individual or someone on his/her behalf is informed that they may file a Recipient Rights Complaint with the Recipient Rights Office alleging a violation of his/her right to treatment suited to condition.

c. If the second opinion determines the individual is not clinically suited for Hospitalization and the individual is a current recipient of other CMHSP services, and a recipient rights complaint has not been filed previously on behalf of the individual, the individual or someone on his/her behalf may file a complaint with the Recipient Rights Office of CMHSP.

3. Request a local appeal

   See Local Dispute Resolution Process section.

4. If a non-Medicaid recipient is not satisfied with the outcome of the Local Dispute Resolution then the recipient can request a State level appeal.

   See MDHHS Alternative Dispute Resolution Process section.

B. Denial Of Access to Community Mental Health Program Services

If an initial applicant for CMHSP services is denied such services, an appropriate referral may be provided.

1. Request a Second Opinion

   a. If an initial applicant for CMHSP services is denied such services, the applicant or his/her guardian, or the applicant's parent in the case of a minor, must be informed of their right to request a second opinion of the Executive Director or designee. The request shall be processed in compliance with Section 705 of the Michigan Mental Health Code and must be resolved **within five (5) business days**.

      i. The Executive director or designee shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level social worker or master's level psychologist.

      ii. If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency situation or urgent situation, the community mental health services program shall direct services to the applicant.

2. Rights Complaint

   The applicant or his/her guardian may **not** file a recipient rights complaint for denial of services suited to condition, as he/she does not have standing as a recipient of mental health services. The applicant or his/her guardian may, however, file a rights complaint if the request for a second opinion is denied.

3. File a local appeal

   See Local Dispute Resolution Process section.

4. If a non-Medicaid recipient is not satisfied with the outcome of the Local Dispute Resolution then the recipient can request a State level appeal

See MDHHS Alternative Dispute Resolution Process section.

C. Denial of Service

Denial through the service authorization process of the request for service or support or denial of the requested amount, scope or duration of a service.

1. Rights Complaint

The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

D. Unreasonable Delay of Services

Unreasonable delay of a service beyond the start date agreed upon during the person-centered planning process and as authorized by the CMHSP. Unreasonable delay is defined as **14 or more calendar days**.

1. Rights Complaint

The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

E. Suspension, Reduction, or Termination of a Currently Provided Service.

1. File a Rights Complaint

The recipient or his/her guardian may file a rights complaint for treatment suited to condition.

2. Request a local appeal

See Local Dispute Resolution Process section.

3. If a non-Medicaid recipient is not satisfied with the outcome of the Local Dispute Resolution then the recipient can request a State level appeal

See MDHHS Alternative Dispute Resolution Process section.

F. Dissatisfaction With Program, Provider, Other

Dissatisfaction about any matter relative to a service other than an action as described above.

1. Grievance

See Grievance Process

2. Rights Complaint

If a complaint alleges a violation of a Mental Health Code protected right.

IV. Grievance Process

A. A recipient, guardian, or parent of a minor child or his/her legal representative may file a grievance at any time regarding dissatisfaction with any aspect of service provision other than an adverse action, as defined in this requirement, or an allegation of a recipient rights violation. The recipient must be given reasonable assistance in completing the forms for filing a grievance. The grievance shall be filed with CMHSP Customer Services, for facilitating resolution of the grievance.

B. Upon receipt of a grievance, the Customer Service Office shall:

1. Log receipt of the verbal or written grievance for reporting to the CMHSP Quality Improvement

Program.

2. Submit the written grievance to appropriate staff including a CMHSP administrator with the authority to require corrective action, none of whom shall have been involved in the initial determination.

3. Notify the recipient, guardian, or parent a minor child of the outcome of the process.

V. Local Appeal Resolution Process

A. Local Appeal Process

Within **five (5) business days** of receipt of the advance notice, the recipient or his/her legal representative, or the parent of a minor child, may file an appeal with the CMHSP Recipient Rights Office. The Recipient Rights Office shall then:

1. Log receipt of the appeal for reporting to CMHSP Quality Improvement Program.

2. Submit the written dispute to appropriate staff, including a CMHSP administrator with the authority to require corrective action, none of whom shall have been involved in the initial determination.

3. Facilitate resolution of the dispute within **fifteen (15) business days** of receipt.

4. Assure an expedited review of the dispute involving an emergent situation where the standard fifteen (15) day time frame would seriously jeopardize the individual's health or safety. Such a review shall be completed within **twenty-four (24) hours** of receipt of all necessary information by relevant CMHSP staff involved in the dispute resolution.

5. Upon a decision by CMHSP staff involved in the local dispute resolution process and within the 24-hour or 15–day time frame, provide written notification of the outcome of the process to the individual, guardian, or parent of a minor child. The written notification shall include:

   a. Information regarding the individual, guardian, or parent of a minor child's ability to access the MDHHS Alternative Dispute Resolution Process and an offer of assistance in doing this;

   b. Information on the individual, guardian, or parent of a minor child or his/her legal representative's right to file a recipient rights complaint with the Recipient Rights Office alleging a violation of the recipient's right to treatment suited to his/her condition.

VI. MDHHS Alternative Dispute Resolution Process

A. Within ten (10) days after receiving notice of the decision reached during the Local Dispute Resolution Process, the individual may request access to the MDHHS Alternative Dispute Resolution process. Access to this process does not require agreement by the CMHSP and may be initiated solely by the recipient.

B. Requests may be received in any written form, but must include the following information:

1. Name of the CMHSP recipient;

2. Name of the guardian legally empowered to make treatment decisions or a parent of a minor child;

3. Daytime phone number where the recipient, legal guardian, or parent of a minor child may be reached;

4. Name of the CMHSP where services have been denied, suspended, reduced or terminated;
5. Description of the service being denied, suspended, reduced, or terminated;
6. Description of the adverse impact on the recipient caused by the denial, suspension, reduction or termination of service.
7. The request should be directed to:

Request for MDHHS Level Dispute Resolution
Division of Program Development, Consultation and Contracts
Bureau of Health and Human Services
Lewis Cass Building - 6th Floor
Lansing, MI 48913

C. MDHHS responsibilities regarding the Alternative Dispute Resolution Process for Persons not receiving Medicaid.

1. If the MDHHS representative, using a "reasonable person" standard, believes that the denial, suspension, termination or reduction of the services and/or supports will pose an immediate and adverse impact upon the recipient's health and safety, the issue is to be referred within **one (1) business day** to the Health and Human Services Division within Mental Health and Substance Abuse Services for contractual action consistent with Section 8.0 of the MDHHS/CMHSP contract.
2. In all other cases, the MDHHS representative shall attempt to resolve the issue with the individual and the CMHSP within **fifteen (15) business days**. The recommendations of the MDHHS representative are non-binding in those cases where the decision poses no immediate impact to the health and safety of the individual.

D. The Office of Recipient Rights will:

1. Provide information about the process for filing;
2. Offer to assist the individual with filing;
3. On the day of the request for Alternative Dispute Resolution is received:

- Date stamp the request
- Fax the request to MDHHS
- Mail the request to MDHHS
- Forward a copy of the request to be logged
- Forward a copy of the request to the Hearings Coordinator

VII. Recordkeeping and Reporting Requirements

The CMHSP must maintain a record of appeals and grievances and their disposition that is available for review by MDHHS upon request.

Reports of disputes, complaints and grievances will be:

A. Reviewed by the CMHSP Quality Improvement Program to identify opportunities for improvement periodically;

B. Periodically provided to the CMHSP governing body for review.

CROSS REFERENCE:

P.A. 516 of 1996

P.A. 258 of 1974

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Guardianship.P3

RESCINDS: July 28, 1999

CATEGORY: Recipient Rights

SUBJECT: Guardianship

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that an adult recipient of services shall be considered and treated as competent in all areas unless a court has determined that the person is not competent or is legally incapacitated and has assigned a guardian, either plenary or partial.

PURPOSE: The purpose of this procedure is to provide guidelines to ensure that the rights of service recipients are fully protected if/when a services recipient lacks the capacity to exercise those rights, and to provide guidelines regarding the role of the Agency in guardianship proceedings.

PROCEDURE:

I. An adult recipient of services shall be considered and treated as competent in all areas unless a court has determined that the person is not competent or is legally incapacitated and has assigned a guardian, either plenary or partial.

II. A guardian's powers are limited to those areas specified in the court order. A recipient of services shall be encouraged to exercise independence in all areas not restricted by guardianship orders.

III. An evaluation of the services recipient's capability to give consent shall precede any Agency initiated guardianship proceedings.

IV. If it is believed that a services recipient who does not have a guardian requires the assistance of a guardian in making ordinary life decisions, and the Program Director, or Executive Director or designee, or Informed Consent Board has recommended that guardianship proceedings be commenced:

A. The client services manager will contact the services recipient, an appropriate family member, friend, or public or private agency or association (other than an agency or association directly providing services to the person) to endeavor to cause a petition for guardianship to be filed with the Probate Court.

B. If no appropriate person is available to petition for guardianship, the client services manager shall do so.

V. Whenever the life of a person presumed legally competent is threatened, when there is doubt whether a person is capable of giving informed consent, and when it is deemed necessary to undertake measures other than surgery or electro-convulsive therapy or other procedures intended to produce convulsion or coma, the Executive Director or designee may direct a petition be made to Probate Court of the county where the person is located to exercise the powers of a guardian or to summarily appoint a temporary

guardian. The medical necessity for the procedure shall be documented, entered into the record of the person, and provided to the Probate Court.

A. This provision for emergency guardianship shall not preclude medical staff from taking life-saving or physical stabilization measures when the life of a person is threatened and there is not time to obtain consent. These measures may be performed without consent after the medical necessity has been documented and the documentation has been entered into the record of the recipient. Consent for necessary continued administration of the emergency procedures shall be sought as soon as possible.

B. The Executive Director or designee may petition Probate Court to exercise powers of a guardian, or to summarily appoint a temporary guardian, whenever a decision should be made by a person presumably legally competent whose life is not threatened but whose capacity to give an informed consent is in doubt, and a time limit for taking action or otherwise making a decision does not allow sufficient time for an informed consent board to be convened and make a determination. A board shall subsequently complete an inquiry and if a majority concludes that person is capable of giving or refusing to give an informed consent, the Probate Court which has assumed or authorized emergency or temporary guardianship powers shall be informed by its next working day and asked to terminate the guardianship.

VI. When a services recipient with a guardian wishes to have the guardianship modified or terminated, the client services manager shall assist the recipient in petitioning the court.

A. The guardianship status of each services recipient shall be reviewed by the interdisciplinary team at least annually to determine need and appropriateness of the current situation.

B. If the interdisciplinary team determines that a guardian of a services recipient should be replaced or that guardianship should be dissolved, the client services manager will petition the Probate Court for replacement or dissolution.

VII. The Agency shall provide or obtain evaluations requested in regard to guardianship proceedings.

A. Any recommendation concerning the scope of the guardianship shall be the minimum necessary to meet the needs of the person and shall encourage development of maximum self-reliance and independence.

VIII. Staff members of the Agency shall not personally act as guardians for any individuals receiving services from the Agency.

IX. CCMHS will not act as guardian for any individuals unless ordered by the court in accordance with Section 628(1) of the Mental Health Code.

X. A copy of the orders for guardianship should be filed in the services recipient's record.

APPLICATION: All programs.

CROSS REFERENCE:

CCMHS Policy – Consent

DMH Administrative Rules Part 6 Rule 330.6006 through 330.6031

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: June 26, 2024 Informed Consent to Psychotropic Chemotherapy.P7

RESCINDS: June 29, 2022

CATEGORY: Medical Services

SUBJECT: Informed Consent to Psychotropic Chemotherapy

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that treatment with psychotropic medication requires education about the medication and informed consent from the person served/parent/guardian.

PURPOSE: To establish procedures for educating persons served, their parents and guardians, about psychotropic medications and to secure proper medication consent(s).

DEFINITION:

The following medication categories shall be considered psychotropic medications:

1. Anti-depressants
2. Anti-psychotic agents
3. Mood stabilizing agents
4. Anti-anxiety agents
5. Sedatives/Hypnotic agents
6. Anti-cholinergic agents used in the treatment of movement disorders
7. Medications to treat ADHD
8. Medications to treat Substance Use Disorders

PROCEDURE:

I. Psychotropic medications shall be prescribed only by a licensed physician, Nurse Practitioner, or Physician Assistant. All such individuals shall be familiar with psychotropic medication through specific training and/or experience. The use of all medications shall follow Food and Drug Administration (FDA) guidelines as noted in the "package insert" also known as "Full Prescription Information".

II. Psychotropic medication shall not be used as punishment, for the convenience of staff, or as a substitute for other appropriate treatment.

III. Informed consent to chemotherapy may be obtained by:

   A. Physician
   B. Nurse Practitioner
   C. Physician Assistant
   D. Registered Nurse

IV. Elements in obtaining informed consent to chemotherapy:

   A. The person who is giving consent must be competent to give consent (refer to "Consent" policy).

B. The person giving consent must be informed of the following:

1. Medication and dosage range;
2. Purpose and benefits of treatment with the medication;
3. Side effects and risks associated with the medication;
4. Precautions;
5. Special storage instructions; and
6. Alternative methods of treatment, if any.

C. The person giving consent must be provided a written summary of the most common adverse effects associated with the medication.

D. The person giving consent must be given the opportunity to ask questions related to the treatment with psychotropic medications for the person served.

E. Consent must be voluntary.

F. The person giving consent must be informed that he/she is free to withdraw consent and to discontinue participation at any time without jeopardizing current services.

G. A consent must be generated by ELMER that lists all CMH medications, medication class, and daily dosages.

H. Signed consent must be scanned under Medication Consents (Signed) section in ELMER.

I. The person giving consent may be informed in person or by telephone.

V. Informed consent to chemotherapy must be obtained:

A. Prior to initial administration of a psychotropic medication (an exception may be made in an emergency situation--refer to "Management of Behavioral Emergency" policy).

B. At least annually for continuation of current treatment.

C. When dosage levels exceed the range specified on the consent.

VI. The health care professional must document that medication education was offered.

VII. Chemotherapy may be administered without consent to persons under a court order to undergo treatment as specified in the order.

VIII. Signatures:

A. If the person giving consent agrees to the recommended treatment with medication, he/she shall sign and date the form.

B. Witness: In this case, the "Witness" is the nurse/nurse practitioner/physician/physician assistant who attests that they have properly informed the person served/parent/guardian according to this policy. It does not necessarily mean that the signature of the "authorized party" has been personally witnessed.

C. If the authorized party is informed by telephone, then the witness should sign and date the form in the appropriate section and send it to the authorized party for signature.

D. If the person served is competent to give consent and verbally consents to treatment, but refuses to sign the form, this must be documented by the witness.

CROSS REFERENCE:

CCMHS Policy - Consent

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024

RESCINDS: June 26, 2024

CATEGORY: Safety

SUBJECT: Management of Behavioral Emergency

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that assaultive and/or aggressive behavior be managed in a safe, non-harmful manner using a method that provides for the best possible care and welfare of both the person and the employee(s) involved. The freedom of movement of a person shall not be restricted more than is necessary to provide mental health services to the person, to prevent injury to the person or others. Approved personal safety and physical crisis intervention/ team intervention, i.e., physical management, may be used only by employees who have current certification in "Nonviolent Crisis Intervention" Training Program by Crisis Prevention International, Inc., and only as a time-limited emergency intervention procedure. Seclusion is **PROHIBITED** in any Agency program or under any circumstances. The use of physical or mechanical restraint, i.e., any physical device used to restrict a person's movement, is **PROHIBITED**.

PURPOSE: Physical management and the request for law enforcement intervention are the only two emergency interventions approved by Michigan Department of Health and Human Services (MDHHS) for use in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm. These intervention procedures are designed to provide employees with appropriate, authorized steps and action they may take to manage the behavior of a person who is momentarily dangerous to others or him/herself. With emphasis on care, welfare, safety and security of all involved, these hierarchical, sequential steps are designed to be used with spontaneous behavioral episodes, not those for which there is currently a treatment plan for correction. These intervention steps are not to be used as punishment, but only to control or manage a dangerous behavior in an emergency situation.

DEFINITIONS:

Behavioral Emergency: Behaviors exhibited by a person that put the person or others at imminent risk of harm.

Emergency Interventions: There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law enforcement intervention.

Imminent Risk: An event/action that is about to occur that will likely result in the potential harm to self or others.

Physical Crisis Intervention/Holding Skills: Techniques to limit mobility of physically aggressive persons in a non-harmful way as a last resort to prevent harm to self or others.

Physical Management: An agency-approved technique used by trained employees as an emergency intervention to restrict the movement of a person by continued direct physical contact in spite of the person's resistance in order to prevent the person from physically harming himself, herself, or others. CCMHS only uses physical management techniques from the "Nonviolent Crisis Intervention" training program by CPI, Inc.

Physical management shall only be used on an emergency basis when a person or the situation is presenting an imminent risk of serious physical harm to himself, herself or others, and lesser restrictive interventions have not reduced or eliminated the risk of harm. The term "physical management" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand. Physical management shall not be included as a component in a behavior treatment plan.

Prone Immobilization: Extended physical management of a person in a prone (face down) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position. **PRONE IMMOBILIZATION of A person OR ANY PHYSICAL MANAGEMENT THAT RESTRICTS A PERSON'S RESPIRATORY PROCESS, FOR THE PURPOSE OF BEHAVIOR CONTROL IS PROHIBITED UNDER ANY CIRCUMSTANCES.**

Request For Law Enforcement Intervention: Calling 911 and requesting law enforcement assistance as a result of a person exhibiting seriously aggressive, self-injurious or other behavior that places the person or others at risk of physical harm. Law enforcement should be called for assistance **ONLY WHEN: CAREGIVERS ARE UNABLE TO REMOVE OTHER PEOPLE FROM THE HAZARDOUS SITUATION TO ASSURE THEIR SAFETY AND PROTECTION, SAFE IMPLEMENTATION OF PHYSICAL MANAGEMENT IS IMPRACTICAL, AND/OR APPROVED PHYSICAL MANAGEMENT TECHNIQUES HAVE BEEN ATTEMPTED BUT HAVE BEEN UNSUCCESSFUL IN REDUCING OR ELIMINATING THE IMMINENT RISK OF HARM TO THE PERSON OR OTHERS.**

Restraint: The use of a physical or mechanical device to restrict a person's movement; specifically, anything that immobilizes or reduces the ability of the person to move his/her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the person or others at risk of physical harm. Restraint does not include the use of a device primarily intended to provide anatomical or physical support that is ordered by a physician, physical therapist or occupational therapist for the purpose of maintaining or improving a person's physical functioning; or safety devices required by law, such as car seat belts or child car seats used in vehicles. **THE USE OF PHYSICAL OR MECHANICAL DEVICES USED AS RESTRAINT IS PROHIBITED IN ALL AGENCY PROGRAMS UNDER ANY CIRCUMSTANCES.**

This definition excludes the following:

Anatomical Or Physical Support: Body positioning or a physical support ordered by a physician, physical or occupational therapist for the purpose of maintaining or improving a person's physical functioning.

Protective Device: A device or physical barrier to prevent the person from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective device as defined here shall not be considered a "restraint" as defined above. However, it must be incorporated in the Individual Plan Of Service (IPOS) through a behavior treatment plan which has been reviewed and approved by the Behavior Treatment Committee (BTC) and received special consent from the person or his/her legal representative.

Medical Restraint: The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the person quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the IPOS for medical or dental procedures.

Safety Devices Required by Law: such as car seat belts or child car seats used while riding in vehicles.

Seclusion: The placement of a person in a room, alone, when freedom to leave the segregated room or area is prevented by any means. **SECLUSION IS PROHIBITED IN ANY AGENCY PROGRAM UNDER ANY CIRCUMSTANCES.**

Therapeutic De-Escalation: An intervention, the implementation of which is incorporated in the person's written plan of service, wherein the person is placed in an area or room, accompanied by an employee who shall therapeutically engage the person in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

Time Out: Voluntary response to the therapeutic suggestion to a person to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.

PROCEDURE:

I. In the event of a BEHAVIORAL EMERGENCY, employees will:

A. Use VERBAL INTERVENTION: To de-escalate a situation before it becomes physical. Utilize de-escalation techniques taught in "Nonviolent Crisis Intervention" training, including but not limited to redirection, setting limits, removing the audience or the person from the situation, and allowing venting.

B. Use DISENGAGEMENT SKILLS / PHYSICAL INTERVENTION – HOLDING SKILLS: To protect the employee(s) and person(s) from injury if behavior escalates to a physical level. If at all possible, this should be accomplished using CCMHS approved disengagement skills and used only by employee(s) who have been properly trained in the use of these techniques. If this is not possible, measures must be taken to safeguard the person and others. Observe carefully until chances of re-occurrence of the behavior have subsided.

C. Use PHYSICAL CRISIS INTERVENTION/TEAM INTERVENTION: If risk behavior places the person or others at imminent risk of serious physical harm to physically stop the person from continuing risk behavior utilizing the least amount of physical management necessary to manage the risk.

1. These interventions are restricted to time limited, age-appropriate holding skills performed by designated, trained and competent employees. Physical holds are to be used only as a last resort and only until the person is able to regain control on his or her own.

2. All physical crisis interventions/team interventions must be observed on an ongoing basis by at least one additional person if possible to monitor for signs of distress and/or whether or not the intervention can be stopped.

3. The continued need for the physical crisis intervention/ holding skills shall be continually reviewed, and a lower level hold shall be used or the hold will end at the earliest possible moment when safety to self and others can be reasonably expected.

4. If circumstances allow, the Program Supervisor is to be notified no later than the time at which a technique or intervention has been used for fifteen (15) minutes. The Program Supervisor will determine whether to request law enforcement intervention. **NOTE:** MDHHS approves calling law enforcement **ONLY WHEN: OTHER PEOPLE CANNOT BE REMOVED FROM THE HAZARDOUS SITUATION TO ASSURE THEIR SAFETY AND PROTECTION, SAFE IMPLEMENTATION OF PHYSICAL MANAGEMENT IS IMPRACTICAL, AND/OR APPROVED PHYSICAL MANAGEMENT TECHNIQUES HAVE BEEN ATTEMPTED BUT HAVE BEEN UNSUCCESSFUL IN REDUCING OR ELIMINATING THE IMMINENT RISK OF HARM TO THE PERSON OR OTHERS.**

5. An intervention or technique may be used up to the time it takes for law enforcement or emergency service providers to arrive – however not to exceed 45 minutes.

6. Medication may be authorized by a physician in an emergency to modify or lessen the severity of the potentially dangerous behavior.

7. If any agency-approved disengagement or holding skills, or emergency medication is used, the employee will file an Incident Report.

D. Use Post-Crisis Techniques: Once the person has reached the Tension Reduction phase, continue to build Therapeutic Rapport. After the situation is calm, schedule a time to debrief the situation with everyone involved. Focus of the debrief should include discussing what can be learned from the incident and determining the likelihood and severity of future crisis behaviors so that these can be reduced or prevented.

II. An Incident Report must be completed whenever a behavioral emergency occurs that requires the use of physical management or request for law enforcement intervention whether or not there is a resulting injury. Refer to the Agency's policy entitled "Report, Investigation and Review of Unusual Incidents".

III. The Rights Officer shall review the policies of contract agencies, contracted inpatient units and child caring institutions to assure compliance with the Mental Health Code and with applicable Federal regulations on seclusion and restraint.

APPLICATION:

All programs.

CROSS REFERENCE:

Mental Health Code Sections 700, 740, 742.

Administrative Rules 7243.

Public Law 106-310, Children's Health Act of 2000 (Section 3207 and 3208)

Title V of the Public Health Service Act (42 USC 290aa et seq.) Section 591 and 595.

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: August 31, 2011

RESCINDS: October 26, 2005

CATEGORY: Recipient Rights

SUBJECT: Obligation to Promote and Protect Rights of Recipients

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that all personnel have a positive duty and obligation to promote and protect the rights of recipients of services to be free from abuse, neglect, retaliation, humiliation, financial or other exploitation, to be treated with dignity and respect, and to receive services in a safe, sanitary and humane treatment environment. This requires all personnel to report any and all concerns about possible violations of the rights of recipients directly to the Office of Recipient Rights in a timely manner.

PURPOSE: The purpose of this policy is to affirm the obligation of all personnel to bring concerns about possible violations of recipient rights directly to the Office of Recipient Rights.

PROCEDURE:

I. Notifying Office of Recipient Rights

   A. When an individual has a concern that the rights of a recipient of services may have been violated or compromised, they are obligated to contact the Office of Recipient Rights directly with this concern.

   B. The individual may contact the Office of Recipient Rights in person, by phone, or in writing.

II. Failure to Notify

   A. The Mental Health code definitions of neglect include the "failure to report abuse or neglect."

   B. Neglect includes acts of commission or omission ... that result from non-compliance with a standard of care or treatment required by law, rules, policies, guidelines, written directives, procedures, or individual plan of service that places or could have placed the recipient at risk of harm.

   C. The failure to notify the Rights Office of concerns of possible rights violations may result in an allegation of neglect.

   D. Appropriate administrative action will be taken when Agency or contract personnel fail to report suspected violations of rights.

CROSS REFERENCE:

CCMHSB Policy - Abuse and Neglect

CCMHSB Policy - Relationship with Recipients and Families

Mental Health Code – Chapter 7

Administrative Rules Part 7

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Person-Centered Planning.P16

RESCINDS: September 25, 2024

CATEGORY: Client Services

SUBJECT: Person-Centered Planning

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) that all persons receiving mental health services have an Individual Plan of Service (IPOS) developed through a person-centered planning process regardless of age, disability, or residential setting. Each person receiving services will receive integrated treatment to maximize their opportunities for recovering (or establishing) the life they believe is worth living.

PURPOSE: To assure the process used to develop the Individual Plan of Service for each person receiving services is consistent with the requirements of the Mental Health Code and the Home and Community Based Services (HCBS) Final Rule, and to create the foundation for care that is self-directed by the person receiving services, who defines his or her own life goals and designs a unique path towards those goals.

DEFINITIONS:

Individual Plan of Services (IPOS): a written individualized plan of services developed with a person receiving services.

Person-centered planning (PCP): a process for planning and supporting the person receiving services that builds upon the person's capacity to engage in activities that promote community life and that respect the person's preferences, choices, and abilities. The person-centered planning process involves allies (families, friends, and professionals) as the person desires or requires and it may be directed by an Independent Facilitator chosen by the person. Any adult receiving mental health services and supports may choose to have their plan implemented through the process of Self-Determination (see CCMHS's Policy entitled "Self Determination").

PROCEDURE:

I. Values and Principles Underlying Person-Centered Planning

Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the person.

- For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach. This approach recognizes the importance of family in the lives of children and that supports and services impact the entire family.

In the case of minor children, the child/family is the focus of planning and family members are integral to success of the planning process.

There are a few circumstances where the involvement of a minor's family may not be appropriate:

- The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Mental Health Code;
- The minor is emancipated; or
- The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process as stated in the Code. Justification of the exclusion of individuals chosen by the recipient to participate in the IPOS shall be documented in the case record.

  - Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person's ability to make choices. Persons who have court-appointed legal guardians shall participate in person-centered planning and make decisions that are not delegated to the guardian in the Guardianship Letters of Authority.

  - Every person has strengths, can express preferences and can make choices. The PCP approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person's goals and plans for community life as well as strategies or interventions used to support the person's success.

  The person's choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for supports and services and how they are provided.

  - The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.

  - Every person contributes to his or her community and has the right to choose how supports and services enable him or her to meaningfully participate and contribute to his or her community.

  - Through the person-centered planning process, a person maximizes independence, creates community connections and works towards achieving his or her chosen outcomes.

  - A person's cultural background is recognized and valued in the person-centered planning process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.

II. Essential Elements of Person-Centered Planning

The following characteristics are essential to the successful use of the PCP process with a person and his/her allies.

A. **Person-Directed.** The person directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

B. **Person-Centered.** The planning process focuses on the person, not the system or the person's family, guardian or friends. The person's goals, interests, desires and preferences are identified with an optimistic view of the future and plans for a satisfying life. The planning process is used whenever the person wants or needs it, rather than viewed as an annual event.

C. **Outcome-Based.** Outcomes in pursuit of the person's preferences and goals are identified as well as services and supports that enable the individual to achieve his or her goals, plans, and desires and any training needed for the providers of those services and supports. The way for measuring progress toward achievement of outcomes is identified.

D. **Information, Support and Accommodations.** The person receives comprehensive and unbiased information on the array of mental health services, community resources, and available providers. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.

E. **Independent Facilitation.** Persons have the information and support to choose an independent facilitator to assist them in the planning process.

F. **Pre-Planning.** The purpose of pre-planning is for the person to gather all of the information and resources (e.g., people, agencies) necessary for effective person-centered planning and set the agenda for the process. Each person (except for those who receive short-term outpatient therapy only, medication only, or those who are incarcerated) is entitled to use pre-planning to ensure successful PCP. Pre-planning, is individualized for the person's needs and is used anytime the PCP process is used.

The following topics are addressed through pre-planning with sufficient time to take all necessary/preferred actions (i.e. invite desired participants):

1. When and where the meeting will be held;
2. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support);
3. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and decide how to deal with them. (What will be discussed and not discussed);
4. The specific PCP format or tool chosen by the person to be used for PCP;
5. What accommodations the individual may need to meaningfully participate in the meeting (including assistance for people who use behavior as communication);
6. Who will facilitate the meeting; and
7. Who will record what is discussed at the meeting.

G. **Wellness and Well-Being.** Issues of wellness, well-being, health and primary care coordination or integration, and supports needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets). If so desired by the person, these issues can be addressed outside of the planning meeting.

PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of per-sonal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

H. **Participation of Allies.** Through the pre-planning process, the person selects allies (friends, family members and others) to support him or her through the person-centered planning process. Planning

helps the person identify who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

III. Individual Plan of Service (IPOS)

A. **Preliminary Plan.** A preliminary plan will be developed within seven (7) days of the commencement of services.

B. **Integrated IPOS.** A full IPOS, developed within ninety (90) days of commencement of services, identifies the desired outcomes of the person and utilizes the comprehensive assessment of mental health disorders, substance use disorders, and intellectual/developmental disabilities to identify services and supports to achieve those outcomes. The IPOS is based on medical necessity and the person's readiness to address specific concerns identified in the assessment.

C. **Review of the IPOS.** Once the IPOS has been developed through the PCP process, it shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition or changes in the person's preferences for support). The person or his/her guardian or authorized representative may request a review of the IPOS at any time.

A formal review of the IPOS with the person and his/her guardian or authorized representative using the PCP process shall occur not less than annually.

Persons are provided with ongoing opportunities to provide feedback on how they feel about service, support and/or treatment they are receiving and their progress toward attaining valued outcomes. Information is collected and changes are made in response to the person's feedback.

D. **Documentation Required within the IPOS.** An IPOS must be prepared in person-first singular language and be understandable by the person with a minimum of clinical jargon or language. The person must agree to the IPOS in writing. Documentation maintained within the IPOS must include:

1. A description of the person's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports;
2. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured;
3. The services and supports needed by the person including those available through CCMHS, other publicly or privately funded programs (such as Home Help, Michigan Rehabilitation Services), community resources and natural supports;
4. The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and supports from the mental health system. All settings meet the requirements of the HCBS Final Rule;
5. The amount, scope and duration of medically necessary services and supports authorized by and obtained through the community mental health system;
6. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports;
7. Documentation of any restriction or modification of additional conditions must meet the standards set forth in section F below;
8. The services which the person chooses to obtain through arrangements that support self-determination;

9. The estimated/prospective cost of services and supports authorized by the community mental health system;
10. The roles and responsibilities of the person, the clinician/supports coordinator/case manager, the allies, and providers in implementing the plan;
11. The person or entity responsible for monitoring the plan;
12. The signatures of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved);
13. The plan for sharing the IPOS with family/friends/ caregivers with the permission of the person;
14. A timeline for review; and
15. Any other documentation required by Section R330.7199 Written Plan of Services of the Michigan Administrative Code.

E. Each person (or his/her court-appointed legal guardian, or authorized representative if one has been designated, or parent in the case of a minor) must be provided a written copy of the IPOS within fifteen (15) business days of the planning meeting date.

F. Any effort to restrict certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:

1. The specific and individualized assessed health or safety need.
2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs.
3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.
4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.
5. A regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. Informed consent of the person to the proposed modification.
8. An assurance that the modification itself will not cause harm to the person.

IV. Organizational Standards

The following characteristics are essential for organizations to provide supports and services using a person-centered planning process:

A. **Individual Awareness and Knowledge.** CCMHS provides accessible and easily understood information, support and, when necessary, training to people using services and supports and those who assist them so that they are aware of:

1. Their right to person-centered planning;

2. The essential elements of person-centered planning;
3. The benefits of this approach and the support available to help them succeed (including pre-planning and independent facilitation).
4. This information is provided at first contact and as appropriate during the course of services.

B. **Person-Centered Culture.** CCMHS provides leadership, policy direction and activities for implementing person-centered planning at all levels of the organization. Organizational language, values, allocation of resources and behavior reflect a person-centered orientation.

C. **Conflict of Interest.** CCMHS ensures that the conflict of interest requirements of the HCBS Final Rule are met and that the person responsible for the PCP process is separate from the eligibility determination, assessment, and service provision responsibilities.

D. **Training.** All Staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in IPOS services or supports implementation are provided with specific training when a new IPOS is developed or when there is a change to the IPOS.

E. **Roles and Responsibilities**. As an individualized process, PCP allows each person to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.

F. **Quality Management.** Best practices for supporting persons served through PCP are identified and implemented (what is working and what is not working in supporting persons receiving services). Organizational expectations and standards are in place to assure the person receiving services directs the PCP process and ensures that PCP is consistently done well.

G. **Residential.** When an individual resides in a group home, both owned/operated by CCMHS and contractual placements, the current IPOS will be maintained either through the EMR utilized on site or as a standalone paper copy. If a paper copy is maintained, it must be done so in a manner appropriate with HIPAA and confidentiality policies of CCMHs.

The residential site is also required to maintain a record that all staff are trained on the current IPOS prior to working with the individual. This may also be maintained in the EMR or as a standalone paper attestation to training.

V. Dispute Resolution

If a person is not satisfied with his or her Individual Plan of Service, the person, a person authorized to make decisions regarding the IPOS, the guardian of the person receiving services, or the parent of a minor may request a review of the plan. The review of the plan shall be completed within 30 days. Services shall continue until a notice of a denial, reduction, suspension, or termination is given in which case the rights and procedures for grievance and appeals take over.

People who have a dispute about the PCP process or the IPOS that results from the process, have grievance, appeals and recipient rights as set forth in detail in the Michigan Mental Health Code, the MDHHS Grievance and Appeal Technical Requirement/ PIHP Grievance System for Medicaid Beneficiaries, and CCMHS policies regarding Grievance and Appeals procedures.

Some of the dispute resolution options are limited to people who have Medicaid and limited in the scope of the grievance (such as denial, reduction, suspension, or termination of services). Other options are available to all persons who receive Michigan mental health services and supports. Clinicians/Supports

Coordinators/ Case Managers and Customer Services staff at CCMHS must be prepared to help people understand and negotiate dispute resolution processes.

CROSS REFERENCES:

MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline

MDHHS Behavioral Health & Developmental Disabilities Administration Person-Centered Planning Policy

Medicaid Managed Specialty Supports and Services 1915 (b)/(c) Waiver Program, Contract Attachment - Person-Centered Planning Policy and Practice Guideline

Medicaid Managed Specialty Supports and Services 1915 (b)/(c) Waiver Program, Contract Attachment – Self-Determination Policy and Practice Guideline

CCMHS Policy – Self-Determination

CCMHS Policy - Advance Directive/Durable Power of Attorney/Plan for Difficult Times/Crisis Plan

CCMHS Policy – Grievance and Appeals Processes – Medicaid & Healthy Michigan (HM)

CCMHS Policy – Grievance and Appeals Processes – Non-Medicaid

CCMHS Clinical Guideline – Independent Facilitation of a Person-Centered Plan

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Pharmacotherapy.P7

RESCINDS: June 26, 2024

CATEGORY: Medical Services

SUBJECT: Pharmacotherapy

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) that Agency Pharmacotherapy is carried out in compliance with all applicable state and federal laws and regulations.

PURPOSE: The purpose of this policy is to identify critical aspects of Pharmacotherapy as carried out at Copper Country Mental Health Services. Pharmacotherapy practices include evaluating, prescribing, dispensing, administering and monitoring medications.

PROCEDURE:

I. Access to Pharmacotherapy, when needed, is provided through direct service provision or referral.

II. Pharmacotherapy is integrated into the Individual Plan of Service.

III. Continuity of Pharmacotherapy is maintained between the primary care physician, and/or any other source that may be prescribing for the person served, and the psychiatrist through written and verbal coordination of care as allowed by a signed Release of Information form.

IV. Physician consultation for medication issues is available 24-hours per day, seven days a week.

V. All CCMHS staff and persons served have ready access to the poison control center telephone number, which is 1-800-222-1222.

VI. As components of Pharmacotherapy, the following elements are considered:

A. Identification in a documentation of any history of drug reactions experienced by the person served.

B. Review of past medication use including: effectiveness, side effects, allergies or adverse reactions.

C. Evaluation of co-existing medical conditions.

D. Screening for and evaluation of common medical co-morbities (such as diabetes) for potential impact on prescribing of medications.

E. Identification of alcohol and other drug use.

F. Special dietary needs and restrictions associated with medication use.

G. Use of over-the counter medications.

H. Use of medications during pregnancy.

I. Necessary laboratory studies, tests, or other procedures.

VII. Informed consent is obtained for each psychotropic medication, unless the administration is necessary to prevent physical injury to self or another, or a court orders the administration.

VIII. The review of Pharmacotherapy activities including errors and other medication-related incidents is a component of the Quality Improvement Program.

IX. All medication orders for Copper Country group home residents are reviewed and/or renewed every 30 days by a physician.

X. The frequency of review of the prescription of a psychotropic medication is set forth in the person's Individual Plan of Service and is based on the person's clinical status.

XI. Education on medication issues of the person served is ongoing as is appropriate to his/her needs.

XII. All Pharmacotherapy-related policies are reviewed by the Nursing Manager and approved by the Executive Director.

CROSS REFERENCE:

CCMHS Policy – Psychotropic Medication

CCMHS Policy – Adverse Reaction to Medication

CCMHS Policy – Preparation, Administration and Documentation of Medications and Treatments

CCMHS Policy – Consent

CCMHS Policy – Informed Consent to Psychotropic Chemotherapy

CCMHS – Use of Pharmacotherapy Treatment Guidelines

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Photo & Fingerprinting Recipients.P6

RESCINDS: August 31, 2016

CATEGORY: Recipient Rights

SUBJECT: Photographing and Fingerprinting Recipients

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to protect and promote the basic human dignity and privacy of recipients of service in regard to audiovisual reproduction and viewing through one-way glass. Further, it is the policy of the Copper Country Mental Health Services Board that no recipient shall be fingerprinted by or as a part of any program.

PURPOSE: The purpose of this procedure is to set forth conditions under which audiovisual reproduction may be made, viewing through one-way glass may occur, and to ensure that proper notification is made, that consent is obtained prior to the photographing, audio recording, video recording, or transmitting of images/voices of recipients or use of one-way glass, and to specify the disposition of the audiovisual products.

DEFINITIONS:

Audiovisual Reproduction: Any reproduction of a person's likeness or voice by still or motion picture photography, audio recording, or video recording. Not included in this definition: x-ray, infrared or microscopic photography.

Expressed Written Consent: Written permission obtained prior to making and using audiovisual reproductions of a recipient which may be viewed by the public, including the proposed use of material, e.g., accompanying newspaper articles, inclusion in brochures, training materials, etc., which is signed by the recipient, parent of a minor, or guardian.

One-Way Glass: Modality for making observations through a glass, which allows for images to be seen in only one direction. The subject being observed is unable to see the observer.

Photography(ing): Includes still pictures, motion pictures or video recording reproductions.

Public News Media: Publications including but not limited to newspapers, magazines, books and other printed materials produced by the public press, business or industrial firms, non-profit associations or public agencies (including mental health agencies) and communication systems capable of transmitting photographs or sound via air or cable, e.g., television and radio.

Recipient: means a person who receives mental health services from CCMHS, or from a provider that is under contract with CCMHS.

PROCEDURE: Audiovisual reproduction or use of one-way glass.

I. Audiovisual reproduction may be made for such purposes and under the conditions set forth below.

A. For identification purposes, expressed written consent must be obtained and the photograph will be kept in the recipient's record.

1. If a photograph is delivered to an individual who is not an employee of Copper Country Mental Health Services for the purpose of identifying a recipient, it is required that:

a. the photograph be returned;
b. no duplication of the photograph be made without approval from the Program Supervisor.

B. To provide services including therapy to the recipient, education and staff development services or presentation to professional groups outside the agency, expressed written consent must be obtained.

C. For personal or social purposes, audiovisual reproductions may be made and used unless the recipient or guardian has indicated his/her objection. Expressed written consent is not required.

1. Use of audiovisual reproductions by the public news media must also be approved by the Executive Director or his designee. The written consent form must be signed by the Executive Director or his designee.

2. If the Director refuses to sign the consent form, despite the affirmative wishes of the recipient, guardian or parent, his/her decision may be appealed by written or verbal notification to the Rights Office.

D. If photographs are required for gathering evidence in an allegation of abuse, consent is not required from the recipient, his/her parent or guardian, but may be taken at the direction of the Executive Director or his designee or the Recipient Rights Officer.

II. Expressed written consent must be obtained and placed in the recipient's file before use of one-way glass or the audiovisual reproduction is made.

A. The consent form is developed and approval is obtained from the recipient, parent or guardian by the Program Supervisor or client services manager.

1. The consent must include an expiration date and cannot be valid for more than a 12-month period but may be renewed through the regular consent process. The exception is identification photographs which are kept in the recipient file.

2. An annual review at the time of the annual reassessment is made to determine if the audiovisual reproduction is still essential to provide services or to determine the name of the resident, i.e., for identification.

3. The consent must state the intended use of the photograph, video recording, or transmission of image/voice.

4. A second written consent must be obtained for any alternative use of audiovisual reproduction of a recipient, i.e., some use other than that originally intended for which consent was executed.

B. A consent granted on behalf of a minor is no longer valid when the recipient reaches 18 years of age.

C. The person from whom consent is requested shall be informed, prior to giving consent, that consent may be revoked prior to the expiration date either orally or in writing by contacting the Recipient

Rights Officer, Program Supervisor or client services manager. This statement must appear on the consent form.

D. A recipient must be advised immediately prior to the time that a picture or video recording is to be taken, or voice recorded or transmitted, and what the intended purpose is and must be afforded an opportunity to object. If the recipient expresses verbal objection to being photographed or to having his/her image/voice recorded or transmitted, such objection shall be honored whether or not the recipient, parent or guardian has previously signed the consent.

E. Oral objection to making or use of audiovisual reproduction, or oral termination of consent for audiovisual reproductions, shall be noted in the recipient's record.

III. The recipient, parent or guardian shall be fully informed of the current and future use of the photographs, video recordings or audio recordings.

A. If an identification photograph is removed from the file for the purpose of identifying a recipient, it must be returned to the file and no duplication of the photograph may be made without approval from the Program Supervisor. Any duplication must also be returned to the file or destroyed.

B. Audiovisual reproductions shall be given to the recipient or destroyed after they are no longer needed for the purpose for which consent was granted or upon discharge of the recipient, whichever occurs first.

IV. Audiovisual recordings and/or photographs of treatment/training sessions made by consumers, guardians, and/or family members are not permitted.

V. Video surveillance of consumers is prohibited everywhere except in a psychiatric hospital.

PROCEDURE: Fingerprinting.

Recipients shall not be fingerprinted by or as a part of any program of the Copper Country Mental Health Services Board.

APPLICATION: All Programs.

CROSS REFERENCE:

Mental Health Code Section 724

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: July 25, 2012

RESCINDS: August 28, 1991

CATEGORY: Protected Health Information (PHI)

SUBJECT: Privileged Communication

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that privileged communication shall be honored according to Section 750 of Act No.258 of the Public Acts of 1974.

PURPOSE: With respect for the right of the person served to privileged communication, disclosure of such information is given only in the circumstances and under the conditions set forth in this procedure.

DEFINITIONS: Taken from Section 750 of Act No.258 of Public Acts of 1974:

Privileged Communication: means a communication made to a psychiatrist or psychologist in connection with the examination, diagnosis, or treatment of a patient, or to other person while the other person is participating in the examination, diagnosis, or treatment.

PROCEDURE:

I. Privileged communications shall not be disclosed in civil, criminal, legislative, or administrative cases or proceedings, or in proceedings preliminary to such cases or proceedings, unless the patient has waived the privilege, except in the circumstances set forth in this section.

II. Privileged communications shall be disclosed upon request, under one or more of the following circumstances:

   A. If the privileged communication is relevant to a physical or mental condition of the patient that the patient has introduced as an element of the patient's claim or defense in a civil or administrative case or proceeding or that, after the death of the patient, has been introduced as an element of the patient's claim or defense by a party to a civil or administrative case or proceeding.

   B. If the privileged communication is relevant to a matter under consideration in a proceeding governed by this act, but only if the patient was informed that any communications could be used in the proceeding.

   C. If the privileged communication is relevant to a matter under consideration in a proceeding to determine the legal competence of the patient or the patient's need for a guardian but only if the patient was informed that any communication made could be used in such a proceeding.

   D. In a civil action by or on behalf of the patient or a criminal action arising from the treatment of the patient against the mental health professional for malpractice.

   E. If the communications were made during an examination ordered by a court, prior to which the patient was informed that a communication made would not be privileged, but only with respect to the particular purpose for which the examination was ordered.

F. When the communications were made during treatment that the patient was ordered to undergo to render the patient competent to stand trial on a criminal charge, but only with respect to issues to be determined in proceedings concerned with the competence of the patient to stand trial.

III. In a proceeding in which subsections (2) and (3) prohibit disclosure of a communication made to a psychiatrist or psychologist in connection with the examination, diagnosis, or treatment of a patient, the fact that the patient has been examined or treated or undergone a diagnosis also shall not be disclosed unless that fact is relevant to a determination by a health care insurer, health care corporation, non-profit dental care corporation, or health maintenance organization of its rights and liabilities under a policy, contract, or certificate of insurance or health care benefits.

IV. Privileged communication may be disclosed pursuant to Section 946 of the Mental Health Code to comply with the duty set forth in that section.

APPLICATION: All programs.

CROSS REFERENCE:

CCMHS Policy – Confidentiality and Confidentiality Appendix 1

CCMHS Policy – Use and Release of Protected Health Information

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: December 9, 2020 Procurement of Goods & Services.P3

RESCINDS: April 27, 2016

CATEGORY: Contracts and Credentialing

SUBJECT: Procurement of Goods and Services

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that transactions of $5,000 and over be conducted, whenever possible, in a manner which encourages open and free competition and value purchasing, but which does not sacrifice nor have an adverse impact on the quality of the services provided. Procurement will follow applicable federal and state laws.

It is the policy of CCMHS to develop and maintain a Provider Network that meets the needs of persons served. CCMHS will continually assess needs of persons served and provide the full array of services in appropriate settings to meet those care needs while evaluating and planning for the expansion, adjustment, and improvement of the Provider Network. Soliciting providers for the service delivery system must be done with due deliberation and sensitivity to procurement and contracting issues. Reimbursement will be the lowest rate paid by other payers for the same or similar service.

PURPOSE: To acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care or service, maintenance of existing care relationships and service networks, creating or expanding options for persons served, movement of a person if the services of a particular provider are not satisfactory, and the business needs of the organization.

PROCEDURE:

I. General Procurement Procedures:

A. The need for procurement must be genuine and is authorized by the Executive Director. CCMHS is not required to contract with providers beyond the number necessary to meet the needs of its persons served and is not precluded from using different practitioners in the same specialty.

B. An avoidable cost analysis/price analysis is completed to determine the necessity and practicality of the purchase or contract.

C. Efforts are made to include small business, minority owned firms, and women's business enterprises.

D. Contracting entities must establish/have advisory boards and fill positions with consumers, as appropriate and if stipulated in the Request For Proposal (RFP).

E. The type of procurement process to be used is determined. (i.e.: Competitive Sealed Bids, Competitive Negotiation, Non-Competitive Negotiation).

F. A process for consumer input into appropriate RFP's is established.

G. The MDHHS Checklist for Procurement will be used as a guide in procurement activities.

H. Where administrative, financial or data processing functions are being considered for a sub-contracting arrangement, federal procurement guidelines will be followed.

I. Essential in guiding the conduct of business of procurement is CCMHS' Code of Ethics, which addresses ethics in procurement.

J. CCMHS will not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of the license or certification.

K. CCMHS will not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatments.

L. CCMHS ensures that it will not employ or contract with providers excluded from participation in federal health care program under either Section 1128 or Section 1128A of the Social Security Act or been previously or currently sanctioned by the Medicaid Program.

M. CCMHS will establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to the people it serves.

N. CCMHS will not contract with a provider who prohibits, or otherwise restricts, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a person served.

II. Methods of Selecting Providers:

A. Depending on the circumstances different methods for selecting providers may be used including:

1. Procurement for Selective Contracting: CCMHS purchases services from a limited number of providers who agree to fulfill contractual obligations for an agreed upon price. CCMHS identifies the specific services to be provided, seeks proposals/price bids, and awards contracts to the best bidders. CCMHS is not required to contract with providers beyond the number necessary to meet the needs of the people it serves and is not precluded from using different practitioners in the same specialty. The prospect of increased volume induces providers to bid lower prices. Competitive procurement is pursued through two methods/processes:

   a. Competitive Sealed Bidding: The process of publicizing government needs, inviting bids, conducting public bid openings, and awarding a contract to the lowest responsive and responsible bidder.

   b. Competitive Sealed Proposal: The process of publicizing government needs, requesting proposals, evaluating proposals received, negotiating proposals with acceptable or potentially acceptable offers, and awarding a contract after consideration of evaluation factors in the RFP and the price offered.

2. Procurement to Obtain Best Prices Without Selective Contracting: Under an "any willing and qualified provider" process, bids can be solicited and used to set prices for a service, and then contract or provider agreements can be offered to any qualified provider that is willing to fulfill the contract and meet the bid price.

3. Non-competitive Solicitation and/or Selection of Providers: Circumstances under which CCMHS may select provider without a competitive procurement process.

   a. The service is available only from a single source;

   b. There is an emergent need for obtaining the service and the urgency does not allow time for competitive solicitation;

   c. After solicitation of a number of sources, competition is determined inadequate;

   d. The services involved are professional services (e.g. psychological testing) of a limited quantity or duration;

   e. The services are unique (e.g. financial intermediaries for persons served using voucher or personal service budgets) and/or the selection of the services provided has been delegated to the person served under a self-determination program; and

   f. Existing residential service systems, where continuity of care arrangements is of paramount concern.

B. In these situations, CCMHS may employ noncompetitive negotiation to secure the needed services, however if CCMHS is planning on restricting or otherwise limiting the number of providers who can participate in the program, a competitive procurement process (either competitive sealed bidding or competitive sealed proposal) must be followed.

C. The single-or-limited-source procurement process involves soliciting interest and negotiating with a single or limited set of providers. Again, this may be used where competition for a service is deemed inadequate or when the uniqueness of the services or other consideration limits competitive procurement possibilities.

D. All organizations or individuals selected for award of a contract will be subject to verification that they are not or have not previously been sanctioned by the Medicaid program resulting in prohibiting their participation in the program.

E. If an organizational provider or a group/individually licensed provider disagrees with a determination by CCMHS in the application process or during review of a provider's status, and wishes to have the matter reviewed at a high level, the provider may do so in accordance with CCMHS' Contract Provider Grievance Dispute and Appeals Policy.

CROSS REFERENCE:

CCMHS Policy – Contracting for Clinical Services

NorthCare Policy - Procurement Process

NorthCare Policy – Network Provider Selection

MDHHS Procurement Technical Requirement

MDHHS Checklists for Procurement

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: August 28, 2024 Professional Assessments & Tests.P2

RESCINDS: July 25, 2012

CATEGORY: Client Services

SUBJECT: Professional Assessments and Tests

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to conduct biopsychosocial and other professional assessments or tests for the purposes of determining level of functioning and treatment needs and to recommend a course of treatment for those individuals requiring or desiring such assessments. Assessments will be conducted by qualified individuals who have the appropriate credentials and have privileges to perform such assessments by the Agency.

PURPOSE: The purpose of this policy is to ensure adherence to applicable rules, regulations and standards in regard to the provision of professional assessments or tests for persons receiving services from the Agency.

PROCEDURE:

I. BIOPSYCHOSOCIAL ASSESSMENT

A. The Biopsychosocial Assessment will be completed at admission and updated annually for individuals receiving treatment and/or support services from the Agency. The annual assessment needs to be completed prior to the Individual Plan of Service (IPOS). This assessment will be completed according to an Agency approved format and will include at a minimum:

1. A relevant history;

2. Information on previous services and supports;

3. Assessment of need for food, shelter, clothing, health care, employment services, educational services, legal services, personal safety strategies, recreational services and transportation.

II. CASE MANAGEMENT/SUPPORTS COORDINATOR ROLE

A. The Case Manager/Supports Coordinator will discuss the need/desire for other professional assessments or tests with the person served and other relevant individuals. The need for a professional assessment may occur at any time; however, the need/desire for assessments will be discussed at least annually (in preparation for the person's annual planning meeting) with the person served.

B. The Case Manager/Supports Coordinator will arrange for the needed/desired assessments or tests to be conducted by an individual qualified to perform such assessments.

III. OTHER PROFESSIONAL ASSESSMENTS

A. An annual Health Care Appraisal or Nursing Assessment must be conducted by an MD or RN for those individuals who reside in adult foster care facilities.

B. Occupational Therapy, Nursing, Physical Therapy, Nutritional and Speech/Language Assessments must be ordered by a physician.

C. An assessment done in preparation for an individual's planning meeting should be completed at least three (3) working days prior to the meeting.

D. The assessments will be completed according to Agency-approved formats and will determine the person's level of functioning, need for treatment/services and will recommend a course of treatment.

E. Assessments are either scanned, uploaded, or directly entered into the person's served electronic medical record in the applicable area.

CROSS REFERENCE:

N/A

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Psychotropic Medication.P8

RESCINDS: June 29, 2022

CATEGORY: Medical Services

SUBJECT: Psychotropic Medication

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that psychotropic medications shall be prescribed only by a prescribing licensed professional within his/her scope of practice. This policy does not limit prescribing to FDA approved indications. A physician may lawfully prescribe an FDA approved medication for an unlabeled indication when such use is based upon sound scientific evidence and sound medical opinion. Psychotropic medication shall not be used as punishment, for the convenience of staff, or as a substitute for other appropriate treatment.

PURPOSE: To establish guidelines for the use of psychotropic drugs for the treatment of disorders of thinking, mood, or behavior caused by a psychiatric illness that are consistent with federal and state guidelines, licensure, regulatory bodies and professional standards of practice.

DEFINITION: A psychotropic medication is any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior. The following medication categories shall be considered psychotropic medications:

1. Anti-depressants
2. Anti-psychotic agents
3. Mood stabilizing agents
4. Anti-anxiety agents
5. Sedatives/Hypnotic agents
6. Anti-cholinergic agents used in the treatment of movement disorders
7. Medications to treat ADHD
8. Medications to treat Substance Use Disorders

PROCEDURE:

I. The indication for the initiation of psychotropic drug use shall be noted with documentation present in the chart to include:

   A. Documentation:

      1. History including comprehensive drug history past/present.
      2. Mental status examination.
      3. Diagnosis by physician, physician assistant, or nurse practitioner.
      4. Medication ordered and signed by appropriately licensed individual.

5. Treatment plan authorized by the physician, physician assistant, or nurse practitioner.
6. Laboratory reports as appropriate to medication ordered.
7. Informed consent.
8. Justification for use including expected outcomes.

B. Dosage Range: References such as the American Hospital Formulary Service - Drug Information, American Medical Association Drug Evaluations, Drug Facts and Comparisons, Physician's Desk Reference (PDR), and the United States Pharmacopeia Drug Information (USP-DI) may be utilized for the purpose of designating dosage range for psychotropic drugs.

C. Justification and rationale of the simultaneous use of more than one psychotropic agent from a category (i.e., Antipsychotic, Antidepressants) must be documented in the clinical record.

D. Persons prescribed psychotropic medications must be seen by the physician, physician assistant, or nurse practitioner at no longer than three-month intervals to assess medical management including therapeutic response and side effects. Medications prescribed and the presence or absence of side effects must be documented at least quarterly in the medical record by the physician, physician assistant, or nurse practitioner.

E. Only medications that are authorized in writing by a physician, physician assistant, or nurse practitioner are given to residents of agency group homes upon leave or discharge from the program. The Service/Support plan or discharge plan shall ensure the person has continuity of medication treatment in these circumstances.

II. Tardive Dyskinesia Screenings:

A. Tardive Dyskinesia screens will be performed by nursing or medical staff on a quarterly basis for persons taking any antipsychotic medication (except Clozapine/Clozaril) prescribed by Agency physicians, physician assistants, or nurse practitioners.

B. Physicians or nurse practitioners may order Tardive Dyskinesia screens in other instances as clinically indicated.

CROSS REFERENCE:

CCMHS Policy - Informed Consent for Psychotropic Chemotherapy

Department of Health and Human Services Administrative Rule 7158

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Recipient Rights Complaints-Appeals.P12

RESCINDS: July 26, 2023

CATEGORY: Recipient Rights

SUBJECT: Recipient Rights Complaints/Appeals

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that the rights of recipients shall be protected in compliance with the Mental Health Code and the Michigan Department of Health and Human Services (MDHHS) Administrative Rules. In addition, this policy ensures that any recipient of services or person acting on their behalf is protected from reprisal or intimidation in filing a complaint.

PURPOSE: To ensure that recipients, and anyone else acting on their behalf, shall have unimpeded access to recipient rights protection and that the Recipient Rights Office shall implement the complaint and appeal processes to ensure that recipients and anyone acting on their behalf receives due process, including its essential elements of notice and an opportunity to be heard by a fair and impartial decision-making entity as required by the Mental Health Code and Administrative Rules.

PROCEDURE:

I. Each recipient, parent of a minor, or guardian shall receive a copy of Your Rights When Receiving Mental Health Services in Michigan upon initial contact with any department of Copper Country Mental Health Services (CCMHS) and a Recipient Rights Complaint Form.

   A. An explanation of rights shall be given to each recipient, parent of a minor, or guardian by the Therapist or client services manager.

   B. The documentation of rights notification shall be placed in the recipient's case record.

   C. The name, address and telephone number of the designated rights officer shall be on the rights booklet.

   D. Rights booklets will be available in group homes and all other service locations.

   E. Copies of CCMHS' Consumer Rights and Responsibilities will be available in all service locations and will be provided by the client services manager/therapist to each recipient, parent of a minor, or guardian annually during the annual reassessment.

II. A recipient, or another individual on behalf of a recipient, may file a rights complaint with the rights office alleging a violation of rights protected by the Mental Health Code or Administration Rules.

   A. A rights complaint shall contain all of the following information:

      1. A statement of the allegations that give rise to the dispute.

      2. A statement of the right or rights that may have been violated.

      3. The outcome that the complainant is seeking as a resolution to the complaint.

B. Each rights complaint shall be recorded upon receipt by the rights office, and acknowledgment of the recording shall be sent along with a copy of the complaint to the complainant within five business days.

C. Within five (5) business days after the rights office receives a complaint, it shall notify the complainant if it determines that no investigation of the rights complaint is warranted.

D. The rights office shall assist the recipient or other individual with the complaint process. The rights office shall advise the recipient or other individual that there are advocacy organizations available to assist in preparation of a written rights complaint and shall offer to refer the recipient or other individual to those organizations. In the absence of assistance from an advocacy organization, the rights office shall assist in preparing a written rights complaint. The rights office shall inform the recipient or other individual of the option of mediation provided under the Mental Health Code.

E. If a rights complaint has been filed regarding the conduct of the Executive Director, the rights investigation shall be conducted by the rights office of another community mental health services program or by the state office of recipient rights as decided by the Board.

F. All rights complaints, filed by recipients or anyone on their behalf, shall be sent or given to the rights officer or rights advisor in a timely manner.

III. The rights office shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. Subject to delays involving pending action by external agencies, the rights office shall complete the investigation not later than 90 days after it receives the rights complaint. Investigation shall be initiated immediately in cases involving alleged abuse, neglect, serious injury, or death of a recipient involving an apparent or suspected rights violation.

A. Investigation activities for each rights complaint shall be accurately recorded by the rights office.

B. The rights office shall determine whether a right was violated by using the preponderance of the evidence as its standard of proof.

C. The rights office shall issue a written status report every 30 calendar days during the course of the investigation. The report shall be submitted to the complainant, the respondent, and the Responsible Mental Health Authority (RMHA). A status report shall include all of the following:

1. Statement of the allegations.
2. Statement of the issues involved
3. Citations to relevant provisions of this act, rules, policies, and guidelines.
4. Investigative progress to date.
5. Expected date for completion of the investigation.

D. Upon completion of the investigation, the rights office shall submit a written investigative report to the respondent and to the Responsible Mental Health Authority. Issuance of the written investigative report may be delayed pending completion of investigations that involve external agencies, including law enforcement agencies and the Department of Human Services. The report shall include the following:

1. Statement of the allegations.
2. Statement of the issues involved.
3. Citations to relevant provisions of this act, rules, policies, and guidelines.

4. Investigative findings.
5. Conclusions.
6. Recommendations, if any.

E. A rights investigation may be reopened or reinvestigated by the rights office if there is new evidence that was not presented at the time of the investigation.

IV. If it has been determined that a right has been violated, the Responsible Mental Health Authority or respondent shall take appropriate remedial action that meets all of the following requirements:

A. Corrects or provides a remedy for the rights violations.

B. Is implemented in a timely manner.

C. Attempts to prevent a recurrence of the rights violation.

D. Is documented and made part of the record maintained by the rights office.

The Responsible Mental Health Authority and each service provider shall ensure that appropriate disciplinary action is taken against those who have engaged in abuse or neglect.

V. The Executive Director shall submit a written summary report to the complainant and recipient, if different than the complainant, and all potential appellants within ten business days after the Executive Director receives a copy of the investigative report.

A. The summary report shall include all of the following:

1. Statement of the allegations.
2. Statement of issues involved.
3. Citations to relevant provisions of this act, rules, policies, and guidelines.
4. Summary of investigative findings
5. Conclusions.
6. Recommendations made by the rights office.
7. Action taken, or plan of action proposed, by the respondent.
8. A statement describing the right to appeal and the grounds for an appeal.

B. Information in the summary report shall not violate:

1. Confidentiality or privileged communications.
2. Rights of any employee (Employee Right to Know Act).

VI. The Recipient Rights Advisory Committee is the CCMHS Board's designated Appeals Committee for recipients' appeals of the summary investigative report. A member of the Appeals Committee who has a personal or professional relationship with an individual involved in an appeal abstains from participating in that appeal as a member of the committee.

A. The recipient rights office shall assure that training is provided to the Appeals Committee as required by Section 755(2)(a) of the Code. Topics shall include the following:

1. Categories of rights violations.
2. The complaint investigation process.
3. Types and weighing of evidence.
4. Explanation of the preponderance of the evidence standard used by the rights office in determining whether a rights violation has occurred.
5. Statuary definition of "appropriate remedial action".
6. Agency disciplinary guidelines.
7. Agency policy/procedures on the appeal process and functions of the Appeals Committee.

B. Not later than 45 days after receipt of the summary report, an appellant may file a written appeal with the Appeals Committee with jurisdiction over the office of recipient rights that issued the summary report.

1. An appeal shall be based on one of the following grounds/criteria:

a) The investigative findings of the rights office are not consistent with the facts or with law, rules, policies, or guidelines.

b) The action taken or plan of action proposed by the respondent does not provide an adequate remedy.

c) An investigation was not initiated or completed on a timely basis.

C. The rights office shall advise the appellant that there are advocacy organizations available to assist in preparing the written appeal and shall offer to refer the appellant to those organizations. In the absence of assistance from an advocacy organization, the rights office shall assist the appellant in meeting the procedural requirements of a written appeal and does not act on behalf of the agency.

D. Within 5 business days after receipt of the written appeal:

1. Members of the Appeals Committee shall review the appeal to determine whether it meets the criteria for appeal, consulting with and receiving technical assistance from the MDHHS Office of Recipient Rights as needed.
2. If the appeal is denied because the criteria was not met, the appellant shall be notified in writing.
3. If the appeal is accepted, written notice shall be provided to the appellant and a copy of the appeal shall be provided to the respondent and the Responsible Mental Health Authority.

E. Within 30 calendar days after receipt of a written appeal, the Appeals Committee shall meet in closed session and review the facts as stated in all complaint investigation documents and shall do one of the following:

1. Uphold the investigative findings of the rights office and the action taken or plan of action proposed by the respondent.
2. Return the investigation to the rights office and request that it be reopened or reinvestigated.
3. Uphold the investigative findings of the office but recommend that the respondent take additional or different action to remedy the violation.
4. Recommend that the Executive Director take appropriate supervisory action with the investigating rights officer if the committee confirms that the investigation was not initiated or completed in a timely manner.

5. Recommend that the Board of the community mental health services program request an external investigation by the MDHHS Office of Recipient Rights.

F. The Appeals Committee shall document its decision in writing within ten working days after reaching its decision, and it shall provide copies of the decision to the respondent, appellant, recipient if different than the appellant, the recipient's legal guardian if any, the Responsible Mental Health Authority, and the Recipient Rights Office. Documentation shall include justification for the decision.

G. If the Appeals Committee directs that the recipient rights office re-open or reinvestigate the complaint, the rights office shall submit another investigative report to the Executive Director within 45 calendar days of receipt of the Appeals Committee's written decision, in compliance with section 778(5). The 45-calendar day timeframe may be extended at the discretion of the Appeals Committee upon a showing of good cause by the rights office. At no time shall the time frame exceed 90 days.

1. Within 10 business days of receipt of the reinvestigation report, the Executive Director shall issue another Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the rights office, and the Appeals Committee.

2. If the findings of the rights office remain unsubstantiated upon reinvestigation, the appellant may file a further appeal to the MDHHS-APPEALS-Level 2 Appeal, if the appellant continues to assert that the investigative findings of the rights office are not consistent with facts or with law, rules, policies or guidelines. The Summary Report shall contain information regarding the appellant's right to further appeal, the time frame for appeal and the ground for appeal. The report shall also inform the appellant of advocacy organizations that may assist in filing the written appeal or offer the assistance of the rights office in the absence from an advocacy organization.

3. If the investigative findings result in the substantiation of a previously unsubstantiated rights violation but the appellant disagrees with the adequacy of the action or plan of action proposed by the respondent, that appellant may file an appeal on those grounds to the Appeals Committee. The Summary Report shall inform the appellant of this right as well as further information as stated in V. A. and VI.B. and C.

H. If the Appeals Committee upholds the findings of the recipient rights office and directs that the respondent take additional or different action, that direction shall be based on the fact that appropriate remedial action has not been taken in compliance with section 780 of the Code.

1. The Appeals Committee shall base its determination upon any or all of the following:

   a) Action taken or proposed did not correct or remedy the rights violation.

   b) Action taken or proposed was/will not be taken in a timely manner.

   c) Action taken or proposed did not/will not prevent a future recurrence of the violation.

2. Written notice of this direction for additional or different action to be taken by the respondent shall also be provided to the RMHA if different than the respondent and the rights office.

3. Within 30 calendar days of receipt of the determination from the Appeals Committee, respondent shall provide written notice to the Appeals Committee that the action has been taken or justification as to why it was not taken. The written notice shall also be sent to the appellant, recipient if different than appellant, the recipient's legal guardian, if any, the RMHA if different than the respondent, and the office.

4. If the action taken by the respondent is determined by the Appeals Committee and/or the appellant still to be inadequate to remedy the violation, the appellant shall be informed by the Appeals Committee of his/her right to file a recipient rights complaint against the RMHA, Executive Director for violation of section 754(3)(c) or 755(3)(b) of the Code.

I. If the Appeals Committee recommends that the board or governing body of the RMHA request an external investigation by MDHHS-Office of Recipient Rights, the Board of Directors may make the request to MDHHS-ORR, in writing, within 5 business days of receipt of the request from the Appeals Committee.

1. Within 10 business days of receipt of the investigative report from the MDHHS-ORR, the Executive Director shall issue a Summary Report in compliance with section 782. The Summary Report shall be submitted to the appellant, recipient if different than the appellant, the recipient's legal guardian, if any, the rights office and the Appeals Committee.

2. The complainant, recipient if different than the complainant, and the recipient's legal guardian, if any, shall be informed in the Summary Report issued by the Executive Director of the right to appeal to the MDHHS Appeals Committee. Notice shall include information on the grounds for appeal as stated in section 784(2), the time frame for submission of the appeal, advocacy organizations that may assist with filing the written appeal, and an offer of assistance by the office of recipient rights in the absence of assistance from an advocacy organization.

3. Not later than 45 calendar days after receipt of the Summary Report, the appellant may file a written appeal to the MDHHS Appeals Committee.

4. If the Summary Report contains a plan of action, the office of recipient rights is provided written notice and evidence of the completion of the plan. If the Summary Report contains a plan of action, and the completed action is different than the proposed, the Executive Director shall assure that the rights office, the complainant, recipient if different than complainant, his/her legal guardian, if any, shall be provided written notice including specific information as to the action that was taken and the date this it occurred. The complainant, recipient if different than complainant, his/her legal guardian, if any, shall be afforded 45 calendar days after receipt of the notice to appeal the appropriate Appeals Committee on the grounds of inadequate action taken to remedy a rights violation.

J. The Appeals Committee shall document its decision in writing as stated in VI. F.

1. The Appeals Committee decision shall include a statement of the appellant's right to appeal to MDHHS Appeals-Level 2 Appeal within 45 days from receipt of the decision. The appellant's written appeal with MDHHS-Appeals shall be mailed to:

MDHHS-Appeals
Level 2 ORR Appeal
P.O. Box 30807
Lansing, MI 48909
FAX: (517) 241-7973

2. An appeal to the MDHHS Appeals-Level 2 Appeal must be based on the allegation that the findings of the rights office are inconsistent with facts, rules, policies, or guidelines; and only after the local Appeals Committee has upheld the finding of an investigation, or, upon reinvestigation, the findings of the office remain unsubstantiated.

3. The Office of Recipient Rights shall help the appellant file a written appeal with the MDHHS-Appeals if so desired.

APPLICATION: All Programs.

CROSS REFERENCE:

CCMHS Policy - Abuse and Neglect

CCMHS Clinical Guideline – Consumer Complaints, Grievances, & Suggestions

Mental Health Code - Chapter 7, Chapter 7-A

MDHHS/CMHSP Contract Attachment C6.3.2.4 Amendment 2

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: April 24, 2013

RESCINDS: March 30, 2011

CATEGORY: Recipient Rights

SUBJECT: Recipient Rights Specific to Recipients Receiving Integrated Treatment for Co-Occurring Disorders

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) to protect the rights of all recipients receiving services and to provide for specific rights for recipients receiving integrated treatment for co-occurring disorders (Administrative Rule 325.14301 et seq.) as well as the Michigan Mental Health Code, Chapters 7 and 7A.

PURPOSE: The purpose of this procedure is to establish the specific rights to which recipients who receive integrated treatment for co-occurring disorders at Copper Country Mental Health Services are entitled.

DEFINITIONS:

Abuse: means either of the following:

1. An intentional act by a staff member which inflicts physical injury upon a recipient or which results in sexual contact with a recipient.
2. Communication made by a staff member to a recipient, the purpose of which is to curse, vilify, intimidate, or degrade a recipient or to threaten a recipient with physical injury.

Integrated Treatment for Recipients with Mental Health and Substance Use Disorders: means a program that offers and provides both substance use disorder and mental health treatment in an integrated manner as evidenced by staffing, services and program content. The program is designed for recipients determined through an assessment process to have both distinct substance use and mental health disorders. Services must be provided through one service setting and through a single treatment plan and represent appropriate clinical standards including stage-based interventions.

Neglect: means that a recipient suffers injury, temporarily or permanently, because the staff or other person responsible for the recipient's health or welfare has been found negligent.

Program Director: means an individual who is appointed by the governing authority of the program or its authorized agent to act on its behalf in the overall management of the program.

Recipient: means an individual who receives services from a licensed substance use disorders program in the state of Michigan.

Sexual Contact: means the intentional touching, by a staff member, of the recipient's intimate parts or the intentional touching of the clothing covering the immediate area of the recipient's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification.

PROCEDURE:

All recipients receiving integrated treatment for co-occurring disorders are entitled to the specific rights listed below in addition to those established for recipients receiving other mental health services. CCMHS adopts the Department of Community Health Mental Health and Substance Abuse Services Recipient Rights Administrative Rules in its entirety.

I. A recipient as defined in the 1981 Administrative Rules for Substance Abuse Service Programs in Michigan shall not be denied appropriate service on the basis of race, color, national origin, religion, sex, age, mental or physical handicap, sexual preference or political beliefs.

II. The admission of a recipient to this program or recipient of prevention services shall not result in the recipient being deprived of any rights, privileges, or benefits which are guaranteed to individuals by state or federal law or by the state or federal constitution.

III. A recipient may present grievances or suggested changes in program policies and services to the program staff, to governmental officials, or to another person within or outside the program. Neither the program nor any program staff member shall in any way impede access or interfere in this process.

IV. A recipient has the right to review, copy, or receive a summary of his or her program records, unless in the judgment of the Program Director, such actions will be detrimental to the recipient or to others for either of the following reasons:

A. Granting the request for disclosure will cause substantial harm to the relationship between the recipient and the program or to the program's capacity to provide services in general.

B. Granting the request for disclosure will cause substantial harm to the recipient.

If the Program Director determines that such action will be detrimental, the recipient is allowed to review non-detrimental portions of the record or a summary of the non-detrimental portions of the record. If a recipient is denied the right to review all or part of his or her record, the reason for the denial shall be stated to the recipient. An explanation of what portions of the record are detrimental and for what reasons, shall be stated in the recipient's record and shall be signed by the Program Director.

V. A program staff member shall not physically or mentally abuse or neglect or sexually abuse a recipient as the terms "abuse" and "neglect" are defined in the Substance Abuse Licensing Section Administrative Rules (and as defined in "Definitions" section above).

VI. A recipient has the right to review a written fee schedule. Any revisions of fees will be approved by the governing authority, and recorded in the administrative record, and all recipients will be notified at least two weeks in advance. Each recipient will be provided a summary of fees, if applicable, during the intake process.

VII. A recipient is entitled to receive an explanation of his or her bill upon request, regardless of the source of payment.

VIII. Should this program engage in any experimental or research procedure, any or all recipients will be advised as to the procedures to be used and have the right to refuse participation in the experiment or research without jeopardizing their continuing services. State and federal rules and regulations concerning research involving human subjects will be reviewed and followed.

IX. A recipient shall participate in the development of his or her Individual Plan of Service. This plan is developed using a person-centered planning process.

X. A recipient has the right to refuse treatment and to be informed of the consequences of that refusal. When a refusal of treatment prevents this program from providing services according to ethical and professional standards, the relationship with the recipient may be terminated, with the Program Director's written approval, upon reasonable notice. Reasons for termination will be recorded in the recipient's record in the discharge summary.

XI. Upon admission, and therefore upon request, each recipient is provided a copy of the program rules. These program rules inform recipients of the infractions which can lead to discharge, and how and in what situations prior notification is given to the recipient who is being considered for discharge. The rules also describe the mechanism for appealing a discharge decision and which staff has authority to discharge. The recipient signs a form that documents that a written copy of the program rules has been received and questions about it have been answered. This form is maintained in the recipient's record.

XII. A recipient shall have the benefits, side effects and risks associated with the use of any drugs fully explained in language, which is understood by him/her. This explanation is provided by a physician or a registered nurse. All recipients receiving psychotropic medications must sign an "Informed Consent to Psychotropic Chemotherapy" consent form.

XIII. A recipient has the right to give prior informed consent, consistent with federal confidentiality regulations, for the use and future disposition of products of special observation and audiovisual techniques, such as one-way vision mirrors, tape recorders, television, movies, or photographs.

XIV. Recipients shall not be fingerprinted by or as a part of any program of the Copper Country Mental Health Services Board.

XV. This policy and procedure shall be provided, by the Program Director, to each member of the program staff. Each staff member shall review this material and shall sign a form, which indicates that he or she understands, and shall abide by this program's recipient rights policy and procedures. A copy of the signed form will be maintained in the staff member's personnel file; a second copy will be retained by the staff member.

XVI. The Program Director shall designate a staff member to function as the program rights advisor. The rights advisor shall:

A. Attend training offered by the office concerning recipient rights procedures.

B. Receive and investigate all recipient rights complaints independent of interference or reprisal from program administration.

C. Communicate directly with the Coordinating Agency Rights Consultant when necessary.

XVII. The staff member designated as rights advisor shall not be a provider of integrated treatment services where staffing permits.

XVIII. Rights of recipients shall be displayed in a public place on a poster to be provided by the Bureau of Health Systems Division of Licensing and Certification, Substance Abuse Licensing Section. The poster will indicate the designated rights advisor's name and telephone number.

XIX. As part of the intake or admission process, each recipient will receive a brochure, which summarizes recipient rights. It is the responsibility of the program staff conducting the intake or admission process to explain to the recipient the rights listed on the brochure in language that is understood by the recipient.

XX. The recipient will then be asked to sign a rights acknowledgement form to indicate understanding of the rights. If he or she refuses to sign, then the refusal and reason given is noted in the recipient's file by the program staff.

XXI. If the recipient is incapacitated, he or she shall be presented with the previously mentioned brochure, explanation of rights and opportunity to document understanding of the rights as soon as feasible, but not more than 72 hours after admission.

XXII. When the Rights Advisor receives a Recipient Rights Complaint, the Rights Advisor will determine if the recipient receives integrated treatment for a co-occurring disorder through the CCMHS Substance Abuse License.

If the recipient is receiving services through the CCMHS Substance Abuse License, the recipient will be provided a review of the information about Substance Abuse Recipient Rights and Mental Health Recipient Rights.

If the recipient is receiving services for substance abuse and mental health, the recipient may file a Recipient Rights Complaint using the mental health process, the substance abuse process, or both.

CROSS REFERENCE:

CCMHS Policy – Consent

CCMHS Policy – Informed Consent to Psychotropic Chemotherapy

CCMHS Policy - Co-Occurring Treatment

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: April 24, 2013

RESCINDS: April 27, 2005

CATEGORY: Recipient Rights

SUBJECT: Relationship with Recipients and Families

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that services be provided in a manner that promotes and protects the dignity and respect of the recipients and their families and significant others.

PURPOSE: To ensure that the recipients and their families are accorded the dignity and respect to which they are entitled.

DEFINITIONS:

Dignity: To be treated with politeness and as an equal. To be addressed in a manner that is not condescending or demeaning.

Respect: To be treated with consideration or appreciation. To protect a recipient's privacy. To be sensitive to cultural differences. To allow a recipient to make choices.

PROCEDURE:

I. Recipients of Mental Health Services are treated with dignity and respect.

   A. Treatment with dignity and respect shall be further clarified by what a reasonable person would expect under similar circumstances.

   B. All CCMHS employees, volunteers, contractual service providers and employees of contractual service providers shall treat recipients and their family members with dignity and respect, being sensitive to conduct that is or may be deemed offensive to the other person.

II. Mental Health Services shall be provided to recipients that are:

   A. suitable to their condition.

   B. provided in a safe, sanitary, and humane treatment environment.

   C. provided in the least restrictive setting that is appropriate and available.

III. Family members and other individuals significant to recipients of services are treated with dignity and respect.

   A. They are given opportunity to provide information to treating professionals.

   B. They are provided opportunity to request and receive educational and coping strategies information about:

      1. the nature of disorders.

2. medications and side effects.
3. available support services.
4. advocacy and support groups.
5. financial assistance.

C. Interactions with family and significant others are conducted in a manner consistent with the confidentiality rights of the recipient.

CROSS REFERENCE:

CCMHS Policy - Confidentiality

CCMHS Policy - Person-Centered Planning

Mental Health Code - Sections 704, 708, 711

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: September 25, 2024

RESCINDS: February 28, 2024

CATEGORY: Reporting Requirements

SUBJECT: Report, Investigation and Review of Unusual Incidents

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that all unusual incidents involving people receiving CCMHS services, employees and/or volunteers will be reported, documented, investigated, and reviewed as required by Michigan Department of Health and Human Services and NorthCare. Further, appropriate follow-up care and/or remedial action will be taken to address any health and safety issues for those involved.

PURPOSE: The purpose of this policy and procedure is to provide standard instructions so that unusual incidents involving persons receiving services, employees and/or volunteers are identified, reported, documented, reviewed and investigated in a timely manner.

DEFINITIONS:

Unusual Incident: An occurrence that disrupts or adversely affects the course of treatment or care of a person receiving services, or the program or the facility administration, and includes but is not limited to:

A. Death of a person who was receiving services or who had received an emergent service within the last thirty (30) calendar days.
B. Attempted suicide by a person receiving services;
C. Any accident or illness that involves an emergency room visit or hospital admission.
D. Any physical or psychological injury of a person(s) receiving services and/or any incident, which could have caused physical or psychological injury.
E. Apparent injury such as bruises, bumps, scratches, limping.
F. Violence or aggression.
G. Serious challenging behaviors such as property damage, attempts at self-inflicted harm or harm to others, unauthorized leave, or fire setting.
H. Suspected or actual abuse or neglect of a person receiving services.
I. Medication errors.
J. Medication refusals unless addressed in the plan of service.
K. Suspected or actual criminal offenses involving people receiving services, including arrests and/or convictions.
L. Use of physical management techniques (see definition below).
M. Calls to police by staff for assistance with an individual during a behavioral crisis situation regardless of whether contacting the police is addressed in a behavioral treatment plan.
N. Use of seclusion or restraint. *NOTE: SECLUSION AND RESTRAINT, AS DEFINED BELOW, ARE PROHIBITED IN ANY AGENCY PROGRAM. SEE CCMHSB POLICY "MANAGEMENT OF*

BEHAVIORAL EMERGENCY".

O. Biohazardous accident.

P. Significant incident in the community involving person(s) receiving services.

Q. Traffic accidents , when a person(s) receiving services is in the vehicle, whether or not there are injuries (Accident Report must also be completed).

R. Employee injury related to a person(s) receiving services (Employee Accident Report must also be completed).

S. Communicable disease or other infection control issues.

T. Use or possession of weapons.

U. Unusual or unauthorized use or possession of licit or illicit substances.

V. Elopement.

W. Any other event that may meet the definition of a reportable event as stated in the "Sentinel Event", "Critical Incident", "Risk Event", or "Immediately Reportable Event" Administrative Guidelines.

Anatomical Support: Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a person's physical functioning.

Director/Designee: May be the Executive Director, Associate Director, Program Director, or Program Manager.

Designated Supervisor: May be the Program Supervisor, Program Manager, Program Director or designated on-call supervisors during non-business hours.

Physical Management: A technique used by trained employee(s) as an emergency intervention to restrict the movement of a person by direct physical contact in spite of the individual's resistance in order to prevent the person from physically harming himself, herself, or others.

Physical management shall only be used on an emergency basis when the person or the situation is presenting an imminent risk of serious or non-serious physical harm to himself, herself or others and when lesser restrictive interventions have been unsuccessful in reducing or eliminating the imminent risk of physical harm. Physical management shall not be included as a component in a behavior treatment plan. **PRONE IMMOBILIZATION OF A PERSON FOR THE PURPOSE OF BEHAVIOR CONTROL IS PROHIBITED UNDER ANY CIRCUMSTANCES.**

Restraint: The use of a physical or mechanical device, material or equipment to restrict a person's movement; specifically, anything that immobilizes or reduces the ability of the person to move his/her arms, legs, body or head freely, for the purposes of the management, control, or extinction of seriously aggressive, self-injurious or other behaviors that place the person or others at risk of physical harm. Restraint does not include the use of a device primarily intended to provide anatomical or physical support that is ordered by a physician, physical therapist, or occupational therapist for the purpose of maintaining or improving a person's physical functioning; or safety devices required by law, such as car seat belts or child car seats used in vehicles. **THE USE OF PHYSICAL OR MECHANICAL DEVICES USED AS RESTRAINT IS PROHIBITED IN ALL AGENCY PROGRAMS UNDER ANY CIRCUMSTANCES.**

Seclusion: The placement of a person in a room, alone, when freedom to leave the segregated room or area is prevented by any means; or the separation of a person from normal program participation in an involuntary manner. Voluntary time-out is not considered seclusion. **SECLUSION IS PROHIBITED IN ALL AGENCY PROGRAM UNDER ANY CIRCUMSTANCES**.

Therapeutic De-Escalation: An intervention, the implementation of which is incorporated in the individual

written plan of service, wherein the person is placed in an area or room, accompanied by an employee who shall therapeutically engage the person in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.

Time Out: Voluntary response to the therapeutic suggestion to a person to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.

PROCEDURE:

I. Employee(s) who witness, discover or are notified of unusual incidents involving persons receiving services shall:

A. Take action immediately to protect, comfort, and assure treatment of the person(s) as necessary.

B. Verbally notify the designated supervisor immediately of any of the following:

1. Death.
2. Apparent serious injury.
3. Suspected abuse or neglect.

C. If the Incident Report includes potential or actual abuse, neglect, seclusion, restraint, an elopement, death, or any other potential rights violation, staff must also contact the Office if Recipient Rights with detail of the reported incident by calling, **(906) 483-5544**, or by sending an ELMER message to the Recipient Rights Officer, **Christopher Gelety**, or Recipient Rights Advisor, **Dianne Stello-Wenberg**, by the end of their shift.

D. Notify RN if incident is health or injury related.

E. Report the incident using the Incident Report Form in the electronic medical record (ELMER) as soon as possible or at least by the end of shift. If an electronic copy cannot be completed for an atypical reason, then a paper copy may be filled out and routed to the appropriate staff as outlined in the CCMHS Clinical Guideline, "Incident Reporting Completion".

F. Document incident in the person's progress/residential/contact notes.

G. At the time of shift change or change of program site (i.e., day program to group home), outgoing employees will verbally report any injuries documented during the previous shifts to the incoming employee(s). Outgoing employees will also report the incident in the program log.

H. Employee(s) will continue to observe persons in their care for signs of changes in the person's condition, such as bruises, bumps, limping, etc., and take any necessary further action.

II. Employees or volunteers who are involved in incidents, which do not involve persons receiving services (e.g., employee injury/accident unrelated to behavior or actions of a person(s) receiving services) shall:

A. Take any necessary, immediate action to provide treatment for injury.

B. Verbally notify the designated supervisor.

C. Report the incident on an Employee Accident Report within 24 hours.

III. REPORTING PERSON completes the Incident Report Form in ELMER or in paper form as indicated on the back of the Incident Report Form and per the "Incident Report Completion" Clinical Guideline. If completing a paper Incident Report, the staff person routes the Incident Report to their supervisor or designee, who reviews and then signs and routes the incident report within one workday to the Executive Assistant at the Copper Country Mental Health offices, 901 W. Memorial Drive, Houghton, Michigan 49931.

If it is not possible to obtain supervisor/designee review and signature within one workday, the report must be routed to the Executive Assistant without the review and signature.

IV. THE EXECUTIVE ASSISTANT:

A. Provides written notification to AFC Licensing and the consumer's guardian within 48 hours of any incident which involves residents of Agency group homes concerning any of the following:

1. The death of a resident.
2. Any accident or illness that requires hospitalization.
3. Incidents that involve any of the following:

a. Displays of serious hostilities.
b. Hospitalization.
c. Attempts at self-inflicted harm or harm to others.
d. Instances of significant destruction of property.

B. The Executive Assistant scans the Incident Report into the Incident Report Database in ELMER.

C. ELMER routes a copy of the Incident Report to the Recipient Rights Officer and the Primary Caseholder.

D. The Primary Caseholder adds additional reviewers who are on the person's treatment team, if necessary, for review, comments, and signature.

V. The Quality Improvement Coordinator:

A. Reviews the Incident Report and informs the Executive Director or designee in the event of any of the following:

1. Serious injuries or illnesses such as those requiring medical hospitalization.
2. Death of a person receiving services.
3. Suspected abuse or neglect by an employee, contract employee or volunteer.
4. Suspected criminal offense.
5. Suspected sexual abuse or inappropriate sexual act of a person who is receiving services.
6. Law enforcement agency has been called to assist.
7. Major property damage has occurred.
8. Significant incident in the community.
9. Traffic accident when persons receiving services were in the vehicle.
10. Serious employee(s) injury.

B. Follows up as necessary and appropriate.

C. Determines if the incident involved a possible violation of one or more rights; if so, initiates a rights complaint with the Rights Office.

D. Determines if the incident involved is a reportable event; if so, takes necessary action to review, report, investigate or initiate a root cause analysis as stated in the "Sentinel Event", "Critical Incident", "Risk Event", or "Immediately Reportable Event" Administrative Guidelines. Also completes required actions in ELMER to report required events to MDHHS.

E. Ensures that internal and external reporting requirements are met.

F. Provides agency programs and committees including the Quality Improvement Committee and Safety Committee with relevant aggregate data and specific Unusual Incident Reports as needed on a regular basis.

1. The Quality Improvement Committee receives and reviews a report of Incident Reports selected by the Quality Improvement Coordinator quarterly.

2. The Safety Committee receives and reviews Incident Reports of accidents, falls, and any other safety related issues quarterly.

3. The Committees review the reports to identify systemic or programmatic trends. The Committees or any individual staff or board member of the Committees have the discretion to request specific reports and analysis when a trend is identified; for example, if medication errors are increasing, a member of the QI Committee may request an in-depth analysis of the errors that have occurred. Further, when a negative trend is identified, any Committee may request a Plan for Improvement from the appropriate Program Supervisor to address the problem. The Committee may make recommendations for improvement, education and training of employee(s), and ways to prevent recurrence. The requesting Committee will monitor the effect of the Plan of Correction and can request further action and/or information as necessary.

VI. NURSING PERSONNEL:

A. Reviews, comments, and signs off on the incident report once it is routed to them through the Incident Report Database in ELMER.

VII. DESIGNATED SUPERVISOR:

A. Completes the bottom section of the Incident Report form as indicated on the back of the paper Incident Report Form and per the "Incident Report Completion" Clinical Guideline.

B. The Supervisor states a plan to prevent re-occurrence of the incident.

C. Routes any paper incident report to the Executive Assistant for scanning within 24 hours of the Incident Report being written.

D. Reviews and signs off on the incident report once it is routed to them through the Incident Report Database in ELMER.

VIII. EXECUTIVE DIRECTOR OR DESIGNEE:

A. The Executive Director or designee, when notified of serious injury or death, shall:

1. Assure that required treatment and protection measures have been taken;

2. Assure notification of the parent of a minor, guardian, and/or other person designated by the person receiving services.

3. Provide direction on any programmatic or administrative action to be taken.

IX. The Incident Report shall be filed as follows:

A. If paper, the original is kept by the Executive Assistant for three (3) months after it is scanned in ELMER.

B. A copy is printed for the group home for staff to read the remedy provided by the Supervisor to prevent the incident from happening again. Staff sign off on the report and then file it in the group

home. The Supervisor will review the incident with staff as needed. Other program sites may keep a copy of an incident report for the Supervisor to review with staff as applicable.

C. The Incident report (or copy) is not placed in the record of the person receiving services and is not considered to be a part of the clinical record.

X. Debriefings are offered following traumatic or emergency situations to provide support to employee(s) and persons receiving services that are involved. These debriefings are documented and the documentation is maintained by the program supervisor.

APPLICATION: All programs.

CROSS REFERENCE:

CCMHS Policy - Job Related Injuries/Accident/Infectious Illness

CCMHS Policy – Review and Reporting of Deaths

CCMHS Policy – Abuse and Neglect

CCMHS Policy – Emergency Medical Treatment-Residential Group Home Residents

CCMHS Policy – Emergency Medical Treatment–Independent Living Settings

CCMHS Policy – Reporting of Auto Accidents

CCMHS Policy – Grievance & Appeals Processes

CCMHS Policy – Grievance & Appeals Processes–Non-Medicaid

CCMHS Policy – Exposure Control Plan

CCMHS Policy – Management of Behavioral Emergency

CCMHS Reporting Requirements Guideline – Incident Report Completion

CCMHS Reporting Requirements Guideline – Sentinel Event

CCMHS Reporting Requirements Guideline – Risk Event

CCMHS Reporting Requirements Guideline – Critical Incidents

CCMHS Reporting Requirements Guideline – Immediately Reportable Event

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: December 13, 2023 Representative Payeeship.P4

RESCINDS: August 31, 2016

CATEGORY: Financial Management

SUBJECT: Representative Payeeship

POLICY: It is the policy of Copper Country Mental Health Services (CCMHS) Board that all funds which are handled by Agency staff because of a Representative Payeeship are kept separate and apart from all funds and monies of the Agency. CCMHS is the representative payee only as a last resort and can only represent persons served.

PURPOSE: The purpose of this policy is to assure that funds the Agency handles on behalf of a person served are protected from fraud, mismanagement, or any other fiduciary misuse.

PROCEDURE:

I. All representative payee funds are accounted for in the name of "Copper Country Mental Health for: *the individual persons served name"*. All monies shall be deposited into a checking and/or savings account at a federally insured financial institution (bank).

II. Direct deposit is required.

III. All checks must be deposited; cash may not be received.

IV. All interest and dividends earned on person served funds remain the property of the person served and are credited directly to that individual's account.

V. Persons served and/or guardians will receive an annual accounting of the person's served funds.

VI. The Agency will take direction from Social Security Administration when the representative payeeship is terminated.

VII. Upon the death of a person served, all remaining conserved funds belong to his/her estate. CCMHS will give conserved funds to the legal representative of the estate. If there is any question concerning the disposition of the conserved funds, the Probate Court will be contacted.

VIII. Accountability:

A. The person served and/or guardian has access to the records of their funds at all times.

B. Agency Staff shall not accept, take or borrow money from a person served, even with the consent of the person served.

C. The monthly bank statements will be mailed directly to the Accounting department and will be balanced to the register monthly. All discrepancies will be reported to the Finance Director.

CROSS REFERENCE:
Social Security Administration Guide for Representative Payees

CCMHS Administrative Guideline – Rep Payee with SSN Information

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Residents Property & Funds.P5

RESCINDS: April 24, 2019

CATEGORY: Recipient Rights

SUBJECT: Resident's Property and Funds

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to handle resident's property and funds in accord with the conditions required by the Mental Health Code, Administrative Rules, Licensing Rules for Adult Foster Care Group Homes and the Home and Community Based Rules.

PURPOSE: To define procedures for use, receipt, handling and disposition of resident property and funds.

DEFINITIONS:

Resident: A person who lives in and receives services in a group home operated by CCMHS or by a provider under contract with CCMHS.

PROCEDURE:

I. The following items of personal property are excluded from resident possession in all Agency Group Homes.

   A. Weapons, such as firearms, knives, or explosives.

   B. Illegal substances and drugs.

II. In the event there is reasonable cause to believe a resident is in possession of an item that is excluded, unlawful or poses a health or safety risk to the resident or others, a search may be conducted in compliance with the Mental Health Code. Justification for a search shall be documented in the resident's record, which shall include: 1) the reason for initiating the search; 2) the names of the individuals performing and witnessing the search; 3) the results of the search, including a description of the property seized. An official receipt shall be issued to the resident and an individual designated by the resident and recorded in the resident's record for items of personal property taken into the possession of the facility. In other than emergency circumstances, a search shall require the approval of the Team Leader or Client Services Manager.

III. Residents are entitled to receive, possess, and use all other personal property, including clothing, except under the following conditions:

   A. The Individual Plan of Service may limit rights to personal property in order to prevent:

      1. Theft, loss, or destruction of the property unless a waiver is signed by the resident and/or guardian. All conditions of the HCBS Final Rule must be met in addition.

      2. Resident from physically harming himself or others.

   B. As required by the HCBS Final Rule and Mental Health Code, any effort to limit access to property or funds, must be:

1. justified by a specific and individualized assessed health or safety need;
2. the minimum limitation necessary to address the need;
3. addressed through the PCP process;
4. determined with the participation of the recipient and the recipient's family, if at all possible;
5. fully explained to the recipient and the recipient's family by the client service manager before implementing the restriction or limitation;
6. approved by the Behavior Treatment Committee; removed when the circumstance that justified its adoption ceases to exist; and is
7. subject to appeal by the resident or another person on the resident's behalf by filing a Recipient Rights complaint.

C. The following requirements must be documented in the IPOS when a specific health or safety need warrants such a limitation:

1. The specific and individualized assessed health or safety need.
2. The positive interventions and supports used prior to any modifications or additions to the PCP regarding health or safety needs.
3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.
4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.
5. A regular collection and review of data to measure the ongoing effectiveness of the modification.
6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
7. The date of expiration.
8. Informed consent of the person to the proposed modification.
9. Assurance that the modification itself will not cause harm to the person.

IV. Items of personal property not subject to an exclusion or limitation shall be permitted to remain with the resident.

A. Residents shall be provided a reasonable amount of storage space for clothing and personal property.

B. Residents are permitted to inspect personal property at reasonable times.

V. Resident Funds – It is recommended all money which is on the person of a resident or which comes to a resident be turned over to the facility for safe keeping.

A. The money shall be accounted for in the name of the resident and recorded periodically in the records of the resident.

1. Resident funds will be reconciled monthly.
2. The resident or guardian will be provided an annual accounting of resident funds.

B. All resident funds, including bank accounts, shall be kept separate and apart from all funds and monies of the facility. Interest and dividends earned on resident funds shall be credited to the resident.

C. Residents shall have access to and use of personal funds that belong to them in reasonable amounts, including immediate access of funds up to $20.00.

D. Staff may take an active role in guiding a resident's use of funds, but there shall not be a prohibition of use of funds, for legal purchases.

VI. Disposition of property or funds on discharge.

A. On discharge, the facility shall deliver to the resident or designated representative those funds accounted for in the resident's name and any personal effects, including those in storage.

B. Upon the death of a resident, the following shall be implemented:

1. A list of personal effects or monies being held by the Agency shall be sent to the nearest relative by registered mail and to the probate court with a statement calling attention to statutes providing for disposition.

2. If there are questions as to rival claims to personal effects or monies, property may be held by the Agency until claims are determined in a probate court.

3. If the nearest relative cannot be contacted, the Agency shall send by registered mail, to the person or entity who paid the funeral expense, a list of personal effects or monies being held by the Agency and a statement calling attention to statues providing for disposition.

CROSS REFERENCE:

CCMHS Policy - Adult Foster Care Home Refunds

CCMHS Policy – Behavior Treatment Committee

Mental Health Code Section 728, 730, 732

Administrative Rules 7139

Adult Foster Care Licensing Rules

Home and Community Based Services Final Rule

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Right to Access Printed Material, Broadcasts, & Recorded Material.P5

RESCINDS: July 31, 2024

CATEGORY: Recipient Rights

SUBJECT: Right to Access Printed Material, Broadcasts and Recorded Material

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to protect recipients' rights to acquire written material, and to listen to or view radio, recordings, television, movies, etc., unless access is generally restricted for all recipients in written house rules or limited for a recipient in the Individual Plan of Service.

PURPOSE: The purpose of this procedure is to ensure that a recipient shall not be prevented from acquiring, at his expense, or from reading, written or printed material or from viewing or listening to television, radio, recordings, or movies available locally or by mail, for reasons of, or similar to, censorship. Any restriction or limitation must have justification, authorization and proper notification.

PROCEDURE:

I. Exercise of the right to access materials shall not be interfered with unless it infringes on the rights of others, is limited for treatment reasons, or is prohibited by law.

A. House rules shall not indicate hours for viewing and listening to television, radio, recordings or movies, and for volume. Provision for the use of earphones or other alternatives shall be considered when the rights of others are involved.

B. The Supervisor shall provide a determination of recipient interest in and for the provision of a daily newspaper.

C. The right to access materials shall not entitle a minor recipient to obtain and keep written material, or to view television programs or movies, over the objection of a minor's parents or guardians or if prohibited by law. Staff may attempt to persuade parents or guardians to withdraw objections to material including television or movies desired by the recipient.

D. The right to access materials shall not entitle an adult recipient to obtain and keep written or recorded material if it is prohibited by law.

II. Any restrictions or limitations on access to materials, unless prohibited by law or included in the house rules, shall be:

A. Written into and justified in the Individual Plan of Service. A provider shall document each instance when a limitation is imposed in the resident's record;

B. Approved by the Supervisor or Program Director and the Behavior Treatment Committee (BTC);

C. Determined with the participation of the recipient and/or the recipient's guardian, if at all possible;
D. For a specific period of time, with at least quarterly review by the team and BTC of continuing need for limitation or restriction.

E. Fully explained to the recipient and his/her family by the client services manager before implementing the restriction or limitation;

F. Removed when the circumstance which justified the limitation ceases to exist;

G. Subject to appeal by the recipient or some other person acting on his/her behalf filing a complaint through the Recipient Rights Office.

APPLICATION: Residential and Day Programs.

CROSS REFERENCE:

CCMHS Policy - Behavior Treatment Committee

Mental Health Code 726

Administrative Rule 7139

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: June 24, 2020 Rights System.P10

RESCINDS: June 28, 2017

CATEGORY: Recipient Rights

SUBJECT: Rights System

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that the rights of recipients shall be protected through the establishment of a Rights System, written policies and procedures concerning the rights of recipients and a simple, accessible mechanism for recipients and others to report apparent violations.

PURPOSE: The purpose of this procedure is to establish the Rights System to ensure that programs are developed, implemented, and supported in a system that does not violate recipient rights; to provide a resource to staff, recipients and other providers on legal rights of recipients; and to ensure immediate response to complaints filed and provide corrective action to address rights problems.

PROCEDURE: The Copper Country Mental Health Services Office of Recipient Rights is comprised of an Officer of Recipient Rights, Rights Advisors for clerical support, and a Recipient Rights Advisory Committee.

I. THE OFFICE OF RECIPIENT RIGHTS:

A. Shall be protected from pressures, which could interfere with impartial, even-handed, and thorough performance of its duties;

1. The Executive Director shall take appropriate action to ensure protection for complainants and rights staff if there is evidence of harassment concerning an apparent violation of rights or a rights complaint.

2. An Advisory Committee shall be appointed and shall be drawn from Center staff, the Community Mental Health Board, government officials, attorneys, and mental health recipient interest groups.

B. Shall have unimpeded access to all the following:

1. All programs and services operated by or under contract to Copper Country Mental Health Services Board.

2. All staff employed by or under contract to Copper Country Mental Health Services Board.

3. All volunteers/students associated with Copper Country Mental Health Services Board.

4. All evidence necessary to conduct a thorough investigation or to fulfill the required monitoring functions.

C. Funding for the office shall be provided by the Copper Country Mental Health Services Board and reviewed by the Recipient Rights Advisory Committee.

D. The Recipient Rights Officer shall have the education, training and experience to fulfill the responsibilities of the office.

E. The CMH Recipient Rights Advisory Committee shall consult with the Executive Director regarding candidates to head the Office of Recipient Rights when a vacancy occurs, and an Officer of Recipient Rights shall not be dismissed without the Executive Director consulting with the Recipient Rights Committee;

F. The Recipient Rights Officer and Agency staff shall participate annually in training activities that are relevant to recipient rights protection.

G. The Recipient Rights Officer and Advisor shall attend and successfully complete the Basic Skills Training programs offered by the Michigan Department of Health and Human Services (MDHHS) Office of Recipient Rights within three months of hire.

H. In addition, the Rights Officer and Rights Advisor will comply with the continuing education requirements identified in the contract attachment.

I. The Recipient Rights Officer and Advisor must complete a minimum of twelve (12) of the required thirty-six (36) credit hours in programs classified as Category I or II. The Recipient Rights Officer and Rights Advisor will acquire at least three (3) continuing education credits each calendar year.

II. THE RECIPIENT RIGHTS OFFICER:

A. shall be subordinate only to the Executive Director;

B. shall not have direct service responsibilities;

C. shall receive, acknowledge and investigate as appropriate reports of alleged violations of rights;

D. may act to resolve disputes relating to apparent violations;

E. may act on behalf of recipients to obtain remedy for any apparent violations;

F. shall otherwise endeavor to safeguard the rights guaranteed by the Mental Health Code;

G. shall provide or coordinate rights activities and functions for all services operated by or under contract with the CMH Board;

H. shall ensure that recipients, parents of minor, guardians, and others have ready access to recipient "Your Rights" pamphlets and complaint forms;

I. shall ensure that all CSM service locations are visited at least annually, or as necessary for protection of rights guaranteed by the Mental Health Code and MDHHS Administrative Rules;

J. shall serve as an ex-officio, non-voting member of the Behavior Treatment Committee, and the Recipient Rights Advisory Committee;

K. shall serve as a consultant to the Executive Director and staff in rights matters;

L. shall provide or ensure training for all CCMHS staff, and providers under contract with CCMHS, within thirty (30) days of hire or the beginning of the contract, and annually thereafter;

M. shall provide or ensure training in the full extent of recipients' rights including recipient complaints/grievances, recipient rights complaints, and appeals;

N. shall update training annually to assure adherence to policy and procedures particularly in the area of "DUE PROCESS";

O. participates in the review and development of Agency policies/procedures and standards relating to recipient rights.

III. THE RECIPIENT RIGHTS ADVISORY COMMITTEE:

A. shall be a committee of at least seven members, appointed by the Copper Country Mental Health Services Board;

B. shall be broadly based so as to represent the varied perspectives of the CCMHSB geographic area. At least one-third of the membership shall be primary recipients or family members and of that one-third, at least one half shall be primary recipients.

C. all members shall have equal voting privileges.

D. the Rights Officer shall be an ex-officio, nonvoting member of the committee;

E. shall meet at a minimum of two times per year;

F. shall have access to the Executive Director;

G. shall assist the Rights Officer in standardizing policies and procedures that are in compliance with the Mental Health Code;

H. shall monitor the activities of the Rights Office;

I. shall provide the Executive Director and the Board with an annual report regarding rights activities;

J. shall serve as a link to the Community Mental Health Board, and shall channel information and communication through the Board Chairperson;

K. shall serve as the Appeals Committee for rights appeals.

L. see Attachment A for further information regarding duties and responsibilities of the Recipient Rights Advisory Committee.

IV. THE RIGHTS ADVISORS:

A. shall be appointed by the Executive Director to provide clerical support to the Recipient Rights Office;

B. shall be under the direction of the Recipient Rights Officer for the purpose of guidance and direction in carrying out the duties associated with the appointment;

C. shall provide forms for rights complaints, on demand, to recipients or others acting on their behalf;

D. shall receive reports or take messages of recipient rights complaints and forward those to the Recipient Rights Office including:

1. verbal reports by the recipient or others acting on his/her behalf;

2. written reports by the recipient or others acting on his/her behalf;

3. anonymous reports by the recipient or others acting on his/her behalf.

E. participate in training activities provided by the Recipient Rights Officer, when approved by supervisor;

F. shall serve as Recording Secretary for the Recipient Rights Advisory Committee;

G. shall facilitate contact with a substitute Recipient Rights Officer in the temporary absence of the CCMHS Recipient Rights Officer.

V. ALL STAFF:

A. All staff are required to cooperate in Recipient Rights Investigations as a condition of employment.

B. Rights office staff, any staff (or other complainant) acting on behalf of a recipient will be protected from harassment or retaliation resulting from recipient rights activities.

C. Appropriate disciplinary action will be taken if there is harassment related to recipient rights advocacy.

D. Appropriate remedial action is taken to resolve violations of rights and to notify the complainants of substantiated violations in a manner that does not violate employee rights.

ATTACHMENTS: Recipient Rights Advisory Committee Duties and Responsibilities

APPLICATION: All programs.

CROSS REFERENCE:

Michigan's Mental Health Code & Administrative Rules

Whistleblower's Protection Act

Bullard-Plawecki Employee Right To Know Act

No-Reprisal System for Reporting Suspicious Activities

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD

ATTACHMENT A

RECIPIENT RIGHTS ADVISORY COMMITTEE

DUTIES AND RESPONSIBILITIES

1. Serve as appointed by the Copper Country Mental Health Services Board.

2. Meet at least semi-annually or as necessary to carry out responsibilities.

3. Participate in education and training in Recipient Rights Policies and Procedures as provided by the Board.

4. Adhere to the provisions of the Open Meetings Act.

5. Maintain a current list of member's names to be available to recipients upon request.

6. Maintain a current list of categories represented to be made available to recipients upon request.

7. Protect the Office of Recipient Rights from pressures that could interfere with the impartial, even-handed, and thorough performance of its functions.

8. Review the funding of the Office of Recipient Rights.

9. Recommend candidates for Director of the Office of Recipient Rights to the Executive Director, and consult with the Executive Director regarding any proposed dismissal of the Director of the Office of Recipient Rights.

10. Serve in an advisory capacity to the Executive Director and the Directors of the Office of Recipient Rights.

11. Review and provide comments on the Annual Report prepared by the Office of Recipient Rights and submitted by the Executive Director to the Copper Country Mental Health Services Board and the Michigan Department of Health and Human Services.

12. Serve as the Appeals Committee for a rights appeal as required by Chapter 7-A of the Mental Health Code.

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: May 28, 2014

RESCINDS: March 26, 2003

CATEGORY: Recipient Rights

SUBJECT: Treatment by Spiritual Means

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) to protect a recipient's right to treatment by spiritual means, if it is not inconsistent with a court order for treatment, does not break the law or does not physically harm the recipient or others.

PURPOSE: The purpose of this procedure is to set forth guidelines and conditions under which a recipient's request for treatment by spiritual means shall be approved or denied, and to provide for an administrative review of denial of a request for treatment by spiritual means.

DEFINITION:

Treatment By Spiritual Means: A spiritual discipline or school of thought upon which a resident wishes to rely to aid physical or mental recovery and includes easy access, at the recipient's expense, both to printed, recorded, or visual material essential or related to treatment by spiritual means and to a symbolic object of similar significance.

PROCEDURE:

I. A request for treatment by spiritual means may be made by the recipient, guardian or parent of a minor recipient.

   A. If at all possible, this request should be made in writing.

   B. The request may be given/made to any staff person involved with the recipient.

   C. The request is immediately forwarded to the client services manager, who informs his/her supervisor and the Executive Director of his Designee of the request.

   D. The written request is filed in the recipient's record.

II. The client services manager is responsible for the decision to approve or deny the request for treatment by spiritual means.

   A. The client service manager will collaborate with other members of the Interdisciplinary Team in order to reach a decision regarding the request.

   B. Approval is to be given in writing to the recipient and to the person requesting treatment by spiritual means, if other than the recipient. A copy of the approval is to be placed in the recipient's record and another copy is forwarded to the client service manager's supervisor.

1. If the person requesting treatment by spiritual means is other than the recipient, assurance must be obtained that the recipient assents to this treatment.

2. The client service manager will incorporate the treatment by spiritual means into the recipient's schedule and will assure cooperation of staff.

3. Opportunity for contact with agencies providing treatment by spiritual means shall be provided in the same manner as recipients are permitted to see private mental health professionals.

4. The "right to treatment by spiritual means" includes the right of recipients or guardians to refuse medication or other treatment on spiritual grounds which predate the current allegations of mental illness or disability, but does not extend to circumstances where either:

   a) A guardian or the Agency has been empowered by a court to consent to or provide treatment and has done so;

   b) A recipient is presently dangerous to self or others and treatment is essential to prevent physical injury.

5. The Agency may appeal to the probate court when there is a refusal on spiritual grounds of medication or other treatment for a minor.

6. The "right to treatment by spiritual means" does not include the right:

   1. To use mechanical devices or chemical or organic compounds which are physically harmful;

   2. To engage in activity prohibited by law;

   3. To engage in activity which physically harms the recipient or others;

   4. To engage in activity which is inconsistent with court-ordered custody or voluntary placement by a person other than the recipient.

C. Denial of the request is to be made in writing to the recipient and the person requesting treatment by spiritual means if other than the recipient. One copy is to be placed in the recipient's record and another copy is forwarded to the client service manager's supervisor.

   1.The denial letter includes the reasons for the denial.

   2.The denial letter includes an explanation of the recipient's (or other person's) right to appeal the decision.

   3.The client service manager's supervisor automatically reviews the decision to deny treatment by spiritual means to assure adherence to Agency policy.

   4. A denial of the request is appropriate if the treatment by spiritual means is inconsistent with a court order for treatment, breaks the law or is or could be physically harmful to the recipient or others.

III. Upon approval for request for treatment by spiritual means:

A. The client service manager will make an effort to collaborate with the provider to the treatment.

1. A "Release of Confidential Information" consent form will need to be signed by the recipient or empowered guardian.

B. If the recipient or empowered guardian agrees, the provider of spiritual treatment will be considered a member of the Interdisciplinary Team and this treatment will be incorporated into the recipient's service plan.

C. Treatment by spiritual means will be reviewed as part of the service plan.

1. If, in the opinion of the Interdisciplinary Team, treatment by spiritual means is having a detrimental effect on a recipient's status, approval may be withdrawn by the team.

IV. The recipient or a person acting on his/her behalf has the right to appeal a denial decision or a withdrawal of approval for treatment by spiritual means.

A. The client service manger's supervisor automatically reviews the decision to deny the request.

B. The recipient or someone acting on his/her behalf may then appeal to the Community Services Director. The appeal should be in writing; the recipient or person acting on his/her behalf may request assistance from any staff person or the Recipient Rights Advisor/Officer.

C. The Community Services Director shall make a written response to the appeal within ten (10) working days of the receipt of the appeal.

D. If the recipient or person acting on his/her behalf is not satisfied with the Community Services Director's decision, an appeal may be made to the Executive Director. The Executive Director shall make a written response to the appeal within ten (10) working days of the receipt of the appeal.

E. Recipients or persons acting in their behalf should also be informed of their right to file a Recipient Rights Complaint.

APPLICATION: Residential and Day Programs

CROSS REFERENCE:

Mental Health Code 752

Administrative Rule 7135

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURE

DATE: October 30, 2024 Use & Release of PHI.P5

RESINDS: May 29, 2019

CATEGORY: Protected Health Information (PHI)

SUBJECT: Use and Release Of Protected Health Information

POLICY: It is the policy of Copper Country Mental Health Services Board (CCMHS) that protected health information (PHI) and all information obtained in the course of providing services in the record of a person served shall be kept confidential and shall not be open to public inspection. The PHI may be disclosed outside the department, community mental health services program, licensed facility, or contract provider, whichever is the holder of the record, only in the circumstances and under the conditions set forth in this policy. To protect the confidentiality of persons served who have a co-occurring disorder, please refer to the CCMHS policy Confidentiality Policy – Appendix 1.

PURPOSE: To assure the right to confidentiality of PHI is protected for persons served and that all use and disclosures are consistent with the Michigan Mental Health Code, Michigan Department of Health and Human Services Administrative Rules, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act (HIPAA).

DEFINITIONS:

Designated Record Set:

1. A group of records maintained by or for a covered entity that is:

    a. The medical records and billing records about individuals maintained by or for a covered health care provider;

    b. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

    c. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

2. For purposes of this paragraph, the term *record* means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Individually Identifiable Health Information: is information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or healthcare clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

a. That identifies the individual; or

b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information (Phi): means individually identifiable health information:

1. Except as provided in paragraph (2) of this definition, that is:

   a. Transmitted by electronic media;

   b. Maintained in electronic media; or

   c. Transmitted or maintained in any other form or medium.

2. Protected health information excludes individually identifiable health information in:

   a. Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;

   b. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and

   c. Employment records held by a covered entity in its role as employer.

Psychotherapy Notes: means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Required By Law: means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. *Required by law* includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Treatment: means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a person served; or the referral of a person served for health care from one health care provider to another.

Use: means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PROCEDURE:

All CCMHS personnel authorized to release records and information must read, understand and comply with this policy.

All CCMHS personnel will adhere strictly to the basic principle that prior consent of the person served is required before release or disclosure of person served information except where a specific law or regulation or the internal administrative needs of the facility require or permit such access without the person's served consent.

A summary of MHC section 748 is kept in the clinical record of each person served.

I. Uses And Disclosures Of PHI - General Rules

1. These policies and procedures shall be compliant with state and federal laws and regulations that have not been preempted by HIPAA and its implementing regulations, including privacy regulations, containing provisions relating to the release of information from the designated record set of a person served.

2. CCMHS will provide the Secretary of the Center for Medicare/ Medicaid Services (CMS) access to PHI in order to investigate or determine CCMHS's compliance with Parts 160, 162, and 164 of HIPAA.

3. A person served or his/her legal representative has a right to review and/or obtain a copy of their PHI per Appendix 2.

4. A person served, guardian, or parent of a minor, after having gained access to treatment records in accordance with this procedure, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the designated record set of the person served by requesting CCMHS to amend the record or shall be allowed to insert a statement into the designated record set amending the information at issue without changing the original documentation per Appendix 4.

5. A person served, guardian, or parent of a minor may request an accounting of disclosures of PHI, which were not for treatment, payment or health care operations per Appendix 5.

6. A person served, guardian, parent of a minor may request a restriction of PHI per Appendix 9.

7. A request for person served information shall be directed to the clinical record staff for processing and documentation.

8. CCMHS must obtain an authorization or give a person served an opportunity to object to a use or disclosure in order to use or disclose person served PHI except when disclosures are mandatory or authorized under the Michigan Mental Health Code, the HIPAA privacy standards, and/or other federal and state laws and regulations per Appendix 3.

9. CCMHS must make all reasonable efforts not to use or disclose more than the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

10. CCMHS may charge a reasonable fee to offset the costs associated with specific categories of requests.

11. Disclosures of PHI made by CCMHS personnel shall be in compliance with all applicable policies and procedures governing such use and disclosure.

12. In the event of any improper use or disclosure of PHI, when such improper use becomes known to the agency, CCMHS will attempt to mitigate any harmful effects to the extent practicable.

13. When disclosure is appropriate, clinical records staff and authorized clinicians will provide copies to

authorized receivers stamped with the re-disclosure information. Each disclosure outside the agency will contain the following notice:

This information has been disclosed to you from records protected by Federal and State Confidentiality Rules (45 CFR part 160 and 164, and Section 748 of the Michigan Mental Health Code).

The Michigan Mental Health Code requires that an individual who receives mental health records shall disclose the records to others "only to the extent consistent with the authorized purpose for which the information was obtained" (MCL 333.1748).

OR

Any Substance Use Disorder Records - information that have been disclosed to you are protected by Federal Confidentiality Rules (42 CFR Part 2).

Federal rules prohibit you from making any further disclosure of information in this record that identifies an individual as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (§ 2.31). The Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any individual with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

14. When information is being requested for evaluation, accreditation, or statistical compilation, the primary clinician will determine whether such disclosure is appropriate for that person served and will determine whether the person served identity may be disclosed.

15. The primary clinician will determine when identification would be harmful to a person served.

16. The Clinical Records Department will retain the original request, the authorization for release of information, and any copies of cover letters in the person served record for the appropriate record retention period for medical and business-related records or for not less than six (6) years from the date of release, whichever is longer.

17. CCMHS can use or disclose de-identified information per Appendix 11.

18. CCMHS will implement administrative, technical, and physical safeguards (i.e. HIPAA Security Rule) to protect the confidentiality and integrity of PHI by the due date of the HIPAA Security standards.

19. CCMHS requires a written, signed, current, valid authorization to release PHI as follows:

CATEGORY	**REQUIRED SIGNATURE**
Adult	The person served or a duly authorized representative, such as court-appointed guardian or attorney. Proof of authorized representation required, such as notarized power of attorney.
Deceased	Executor/administrator/personal representative of the estate as authorized by Letters of Authority.
Unemancipated Minor	Parent, next of kin, or legally appointed guardian/attorney (proof of relationship required).
Unemancipated Minor (minor requesting services on	Same as adult above for first 12 sessions. Any disclosures thereafter will require signature of parent or guardian.

CATEGORY	REQUIRED SIGNATURE
their own).	
Emancipated Minor	Same as adult above.
Psychiatric Program	Same as adult above. CCMHS requires a signed authorization for Treatment Payment Operations.

II. Uses And Disclosures For Which An Authorization, Or Opportunity To Object Are Not Required

When requested, CCMHS personnel may use or disclose PHI to the extent that, such use and disclosure is required by law and the use and disclosure complies with and is limited to the relevant requirements of such law. PHI shall be used or disclosed only under one or more of the following circumstances:

1. For treatment, payment or health care operations as follows:

   a. For CCMHS's own treatment, payment, or health care operations. Information shall be provided as necessary for treatment, coordination of care, or payment for the delivery of mental health services, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.

   b. Disclose PHI for treatment activities of a health care provider.

   c. Disclose PHI to another covered entity or a health care provider for payment activities of the entity that receives the information.

   d. Disclose PHI to another covered entity for health care operation activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is:

      (i) For conducting quality assessment and improvement activities,
      (ii) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
      (iii) For the purpose of health care fraud and abuse detection or compliance.

2. Pursuant to valid orders or subpoenas of a court of record, subpoenas of the legislature, unless the information is made privileged by law as outlined in Appendix 6;

3. To a prosecuting attorney as necessary for the prosecuting attorney to participate in a proceeding governed by the Michigan Mental Health Code if it is either:

   a. Non-privileged information disclosed or;

   b. Privileged information disclosed pursuant to MHC section 750 (2) including:

      (i) Names of witnesses to acts which support the criteria for involuntary admission;
      (ii) Information relevant to alternatives to admissions to a hospital;
      (iii) Other information designated in CCMHS policies.

4. To an attorney for the person served, with the authorization of the person served, the guardian with authority to consent, or the parent with legal physical custody of a minor. Attorneys representing recipients may review records only on the provider's premises and upon presentation of identification and the recipient's consent, or a release executed by the parent or guardian;

5. To an attorney who has been retained or appointed to represent a minor pursuant to an objection to hospitalization of a minor shall be allowed to review the records.

6. To a private physician, or psychologist, appointed by the court or retained to testify in civil, criminal, or administrative proceedings, upon presentation of identification and a certified court order, upon the provider's premises. Before the review, notification shall be provided to the reviewer and to the court if the records contain privileged communication which cannot be disclosed in court, unless disclosure is permitted because of an express waiver of privilege, or because of other conditions that by law permit or require disclosure.

7. A prosecutor may be given non-privileged information, or privileged information, which may be disclosed if it contains information relating to names of witnesses to acts which support the criteria for involuntary admission, information relevant to alternatives to admission to a hospital, or facility, and other information designated in policies of the governing body.

8. If necessary to comply with another provision of law. In the case that a request for disclosure is received based on a federal or state law other than used in this policy and procedure, refer that request to CCMHS's Privacy Officer;

9. To the Department of Health and Human Services or other health oversight agency, if the information is necessary in order for said entity to discharge a duty placed upon it by law. Oversight does not include investigation or activity in which the person served is the subject of the investigation or activity that does not arise out of and is not directly related to the receipt of health care, claim for public benefits related to health, or qualification for/receipt of public benefit or services when the health of the person served is integral to qualification or receipt;

10. To the office of the auditor general, if the information is needed for that office to discharge its constitutional responsibility;

11. For the purpose of a recipient applying for or receiving benefits without the consent of the recipient or legally authorized representative, only if the benefits shall accrue to the provider, or shall be subject to the collection for liability for mental health service;

12. To a surviving spouse of the recipient or, if there is no surviving spouse, to the individual or individuals most closely related to the deceased recipient within the third degree of consanguinity as defined as in civil law, for the purpose of applying for and receiving benefits;

13. To an adult if all of the following apply:

    a. A request has been received from the person served;

    b. The person served does not have guardian and has not been adjudicated legally incompetent.

    c. The case entry has been made after March 28, 1996. The information shall be disclosed as expeditiously as possible but in no event later than 30 days after receipt of a request or, if the person served is receiving treatment before the person served is released from treatment, whichever is earlier.

14. As necessary for the purposes of outside, evaluation, accreditation, or statistical compilation, provided that the individual who is the subject of the information can be identified only if such identification is essential in order to achieve the purpose for which the information was sought or if preventing such identification would clearly be impractical, but in no event if the subject of the information would likely be harmed by the identification;

15. To providers of mental or other health services or a public agency, if there is a compelling need for disclosure based upon a substantial probability of harm to the person served or other individuals.

16. Staff shall report suspected abuse or neglect to Protective Services in accordance with Act 238 of the Public Acts of 1975 and Act 519 of the Public Acts of 1982 and CCMHS Policies and Procedures.

17. To individuals or committees assigned a peer review function, including reviewing the quality and appropriateness of services, shall be used only for peer review, are not public records, and are not subject to court subpoena.

18. To an identified representative of Disability Rights Michigan in accordance with Public Law 94-103, 89 Stat. 486, Public Law 99-319, 100 Stat. 478, and Act 258 of the Public Acts of 1974, as amended per appendix 7.

19. Upon receipt of a written request from the Department of Health and Human Services/Child Protection Services that a child abuse or neglect investigation has been initiated involving a person who has received services from CCMHS, mental health records and information that is pertinent to the investigation shall be released within 14 days of the request in accordance with Act 258 of the Public Acts of 1974, as amended, per Section 748a.

20. The holder of the record shall not deny or delay disclosing information that is a mandatory disclosure listed above per:

    a. A request from the attorney of a person served even if the legally empowered guardian or the parent of a minor requests a delay, or;

    b. A case record made after March 28, 1996, which is being disclosed to an adult, upon request by the person served, if the person served does not have a guardian and has not been adjudicated legally incompetent.

21. Attorneys who are not representing recipients may review records only if the attorney presents a certified copy of an order from a court directing disclosure of information concerning the recipient to the attorney. An attorney shall be refused information by phone, or in writing, without the consent or release from the recipient unless the request is accompanied, or preceded, by a certified copy of an order from a court ordering disclosure of information to that attorney.

III. Uses And Disclosures Requiring An Opportunity For The Individual To Agree Or To Object

If the person served is present for, or otherwise available prior to a use or disclosure to a family member, other relative, or a close personal friend of the person served, or any other person identified by the person served, CCMHS may use or disclose the PHI if it is documented in the clinical record and:

a. The person served agrees and the agreement is documented in a progress note;

b. The clinician provides the person served with the opportunity to object to the disclosure, and the person served does not express an objection.

IV. Disclosures - Where Authorization Is Required

Except as otherwise provided in this policy, CCMHS staff may not disclose PHI without authorization that is valid under this policy. Valid authorization can be obtained with an informed consent from the person served, that person's guardian with authority to provide informed consent, the parent of a minor,

or the court appointed legal representative or executor of the estate if the individual is deceased. Confidential PHI can be disclosed with a valid authorization to all of the following:

a. Providers of health services, other than CCMHS, when these providers receive the authorized portions of the clinical and medical record;

b. The person served, his or her guardian, the parent if a minor child, any other individual or agency unless in the written judgment of the holder of the record the disclosure would be detrimental to the person served or others unless the person served is an adult and does not have a guardian.

When information is disclosed for clinical purposes and with appropriate authorization, the holder of the record shall release a copy of the entire medical and clinical record to the provider of mental health services. Release of the entire medical and clinical record must be done in a circumstance where it is clinically appropriate to do so.

V. Disclosures - Detrimental Information

For case records entries made subsequent to March 28, 1996, information made confidential by Sec. 748 of the Mental Health Code shall be disclosed to an adult, upon request of the person served, if the person served is legally competent. The information shall be disclosed as expeditiously as possible but in no event later than 30 days after receipt of a request or, if the person served is receiving treatment before the person served is released from treatment, whichever is earlier. This information may not be withheld even if the holder of the record judges it would be detrimental to the person served or others. See Appendix 2.

Unless the above applies to a request for PHI, the holder of the record may make a determination that disclosure of PHI may be detrimental to the person served or others and decline to disclose the PHI or determine whether part of the PHI may be released without detriment. See Appendix 2.

To review PHI for a determination of detriment, CCMHS staff will follow the procedure set forth in Appendix 8. If an individual does not receive the requested PHI because a determination of detriment or any other reason, they may file a recipient rights complaint and/or a complaint with the CCMHS Privacy Officer.

All supervisors are responsible for implementing this policy. CCMHS personnel who violate this policy are subject to discipline up to and including termination from employment in accordance with CCMHS Sanction Policy.

List of Appendices:

1. Notice of Privacy Practices Procedure
2. A Person Served or His/Her Legal Representative Access To Records And Schedule of Fees for Copying Procedure
3. Authorization For Use and Release Of PHI Procedure
4. A Persons Served Right To Request Amendment Of PHI Procedure
5. Accounting Of Disclosures Procedure
6. Court Order Or Subpoena Of A Court Or Administrative Tribunal Procedure
7. Disclosures to Protection and Advocacy Procedure
8. Review for Detriment Procedure

9. A Persons Served Request For A Restriction Of Uses and Disclosures of PHI Procedure
10. Verification of Identity Procedure
11. De-identifying Information Procedure
12. HIPAA Privacy Practices Training Procedure
13. Business Partner/Associate Agreement Procedure
14. HIPAA Sanction Procedure

CROSS REFERENCE:

CCMHS Policy - Service Record System

CCMHS Policy - Confidentiality

CCMHS Policy - Minimum Necessary Protected Health Information

Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 748a, and 750.

Michigan Department of Health and Human Services Administrative Rules Section R 330.7051 Rule 7051.

45 CFR part 160 et al.

45 CFR part 164 et al.

42 CFR part 2 et al.

CCMHS Clinical Guideline – Privacy Notices

APPENDIX 1

SUBJECT: NOTICE OF PRIVACY PRACTICES PROCEDURE

PROCEDURE:

1. The Notice of Privacy Practices will be posted at all Copper Country Mental Health Services Board (CCMHS) facilities in areas accessible to persons served. It will also be posted on the CCMHS website at http://cccmh.org and downloadable in a PDF format.

2. If the person served cannot read or understand the Notice of Privacy Practices, accommodations will be provided. Contact the Customer Services Coordinator for assistance.

3. The designated responsible staff shall provide the CCMHS Notice of Privacy Practices and NorthCare Notice of Privacy Practices to each person served or their legal representative upon admission to services. In an emergency treatment situation, a copy of the notices will be provided as soon as reasonably practicable.

4. If the person served does not have a current acknowledgment (within 6 years) on file, one shall be provided. The retention period for the Notice of Privacy Practice for protected health information shall be maintained for a maximum of six years following the date of creation or last revision date.

5. A signed acknowledgment of the receipt of the Notice of Privacy Practices will be maintained in the person served permanent clinical record. If a signed acknowledgment of receipt of the notice is not obtained and a good faith effort was made, the effort made and the reason why the acknowledgment was not obtained shall be documented.

Program supervisors are responsible for implementing this procedure.

APPENDIX 2

SUBJECT: A PERSON SERVED OR HIS/HER LEGAL REPRESENTATIVE ACCESS TO RECORDS AND SCHEDULE OF FEES FOR COPYING PROCEDURE

A person served, guardian, or parent of a minor has a right to inspect and/or obtain a copy of their PHI in a designated record set, for as long as the PHI is maintained in said designated record set.

PROCEDURE:

1. All requests to review or obtain a copy must be made in writing to the CCMHS's Records Department.

2. CCMHS will process requests for information from person's served records in a timely, consistent manner as set forth in this procedure.

3. For case records entries made subsequent to March 28, 1996, information made confidential by Section 748 of the Mental Health Code shall be disclosed to an adult, upon request by the person served, if the person served is legally competent. Release is done as expeditiously as possible but in no event later than the earlier of 30 days of a request or, if the person served is receiving treatment before the person served is released from treatment. This information may not be withheld even if the holder of the record judges it would be detrimental to the person served or others.

4. Unless section 748(4) of the act (as stated above) applies to the request for information, the director of the provider may make a determination that disclosure of information may be detrimental to the person served or others. If the director of the provider declines to disclose information because of possible detriment to the person served or others, then the director of the provider shall determine whether part of the information may be released without detriment. A determination of detriment shall not be made if the benefit to the person served from the disclosure outweighs the detriment. If the record of the person served is located at the resident's facility, then the director of the provider shall make a determination of detriment within 3 business days from the date of the request. If the record of the person served is located at another location, then the director of the provider shall make a determination of detriment within 10 business days from the date of the request. The director of the provider shall provide written notification of the determination of detriment and justification for the determination to the person who requested the information. If a determination of detriment has been made and the person seeking the disclosure disagrees with that decision, he or she may file a recipient rights complaint with the Office of Recipient Rights of CCMHS or the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights.

Record of Disclosures

CCMHS clinical records department and authorized clinicians will keep a record of all disclosures which includes:

a. Verification of the identity of the individual requesting disclosure (see Appendix 10).

b. Date request was received;

c. Information released and date released;

d. Fee charged;

e. To whom it is released;

f. The purpose stated by the person requesting the information;

g. A statement indicating how the disclosed information is germane to the stated purpose;

h. The subsection of Section 748 of the Mental Health Code, or other applicable law, under which a disclosure was made;

i. A statement stamped on the information that the individual receiving confidential information shall disclose the information to others only to the extent consistent with the authorized purpose for which the information was obtained and in accordance with Section 748.

Fee Schedule

If a person served requests a copy of their PHI, CCMHS may charge a reasonable, cost-based fee for the copying, including the labor and supply costs of copying. If the person served requests the information to be mailed, the fee may include the cost of postage. CCMHS has established the following fees for copies of patient records:

a. The first copy of the person served record will be free of charge to the person served only. The PHI that is released to the person served shall be logged in the clinical record, disclosure log of the person served.

b. CCMHS may charge up to 10 cents per page and the hourly wage of the records staff person copying the PHI, times the number of hours it takes to copy the PHI. An invoice prepared by the records staff person shall be included in the packet of PHI. Copy of the invoice shall be sent to the billing office.

c. The Executive Director or designee has the authority to waive fees.

LEGAL AUTHORITY

A. Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748 and 752.

B. 45 CFR Part 164 Section 524.

APPENDIX 3

SUBJECT: AUTHORIZATION FOR USE AND RELEASE OF PHI PROCEDURE

PROCEDURE:

1. An authorization for use or disclosure (release) of PHI may not be combined with any other document to create a compound authorization.

2. The authorization must be written in plain language.

3. CCMHS may condition the provision of health care, that is solely for the purpose of creating PHI for disclosure to a third party, on an authorization for the disclosure of PHI to such third party.

4. An individual may revoke an authorization at any time except to the extent that the covered entity has taken action in reliance thereon.

5. CCMHS must document and retain any signed authorization. The authorizations will be filed in the medical record under the release section of the chart.

6. A valid authorization under this section must contain at least the following elements:

    a. A description of the information to be used or disclosed.

    b. The name or other specific identification of the person(s) or class of persons authorized to make requested use or disclosure.

    c. The name or other specific identification of the person(s) or class of persons to whom the covered entity may make the requested use or disclosure.

    d. An expiration date or expiration event that relates to the individual or the purpose of the use or disclosure.

    e. A description of each purpose of the requested use or disclosure.

    f. A statement of the individual's right to revoke authorization and the exceptions to the right to revoke, together with a description of how the individual may revoke the authorization.

    g. A statement that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the person served and no longer be protected by this rule.

    h. Signature of the individual and date; and

    i. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual.

    j. A statement that CCMHS will not condition treatment, payment, enrollment or eligibility for benefits on the person served signing the authorization.

7. Any use or disclosure of psychotherapy notes requires a valid authorization except:

   a. Use by the originator of the psychotherapy notes for treatment;

   b. Use or disclosure by CCMHS for its own internal training programs;

   c. Use or disclosure by CCMHS to defend itself in a legal action or other proceeding brought by the person served;

   d. To the person served;

   e. Uses and disclosures required by law;

   f. Uses and disclosures for health oversight of the originator;

   g. Uses and disclosures by Coroners and Medical Examiners;

   h. If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

8. CCMHS will not consider an authorization valid if:

   a. The expiration date has passed or the expiration event is known by CCMHS;

   b. The authorization is not filled out completely;

   c. CCMHS knows that the authorization has been revoked;

   d. The authorization is combined with another document;

   e. Treatment, payment, enrollment or eligibility is conditioned upon the receipt of a signed authorization from the person served;

   f. CCMHS knows that material information in the authorization is false.

LEGAL AUTHORITY

A. Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 748 (a), and 750.

B. 45 CFR Part 164 Section 508.

APPENDIX 4

SUBJECT: A PERSON SERVED RIGHT TO REQUEST AMENDMENT OF PHI PROCEDURE

PROCEDURE:

1. Right To Amend
   A person served or his/her legal representative has the right to request CCMHS to amend PHI or a record about the person served in a designated record set for as long as the PHI is maintained in the designated record set.

   A person served or his/her legal representative must submit a written request for amendment by providing a reason to support a requested amendment directly to the Privacy Officer.

   The Privacy Officer must act on the individual's request for an amendment no later than thirty (30) days after receipt of such a request. If the Privacy Officer is unable to act on the request within the thirty (30) days, the individual will be notified in writing the reasons for the delay and the expected date that action will be completed. This delay will not exceed an additional thirty (30) days. This will be the only extension allowed.

   The Privacy Officer may deny an individual's request for amendment, if it is determined that the PHI or record that is subject of the request:

   1. Was not created by the covered entity, unless the person served provides a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
   2. Is not part of the designated record set;
   3. Would not otherwise be available for inspection under 45 CFR 164.524 of the Privacy Rule; or
   4. Is deemed to be accurate and complete.

2. Statement Correcting or Amending Information
   A person served, guardian, or parent of a minor, after having gained access to treatment records, may challenge the accuracy, completeness, timeliness, or relevance of factual information in the record of the person served. The person served, guardian, or parent of a minor shall be allowed to insert into the record a statement correcting or amending the information at issue. The statement shall become part of the record.

3. Notification of Amendment to Relevant Persons
   Obtain the individual's identification of and agreement to have CCMHS notify the relevant persons with whom the amendment needs to be shared and make reasonable efforts to inform and provide the amendment within a reasonable time to:

   a. Persons identified by the individual as having received PHI about the individual and needing the amendment; and
   b. Persons, including business associates, that CCMHS knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to the detriment of the person served.

LEGAL AUTHORITY

A. Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 749, 750.

B. 45 CFR Part 164 Section 526.

APPENDIX 5

SUBJECT: ACCOUNTING OF DISCLOSURES PROCEDURE

PROCEDURE:

1. Disclosure Log

A. A disclosure log entry is required when a disclosure of information in the designated record set is made to parties other than those identified in the exceptions below. The disclosures shall be documented in the disclosure log of the consumer chart. The person served is also entitled to an accounting of disclosures made by business associates of CCMHS.

B. An individual's right to this accounting is limited to at least a six (6) year period or less prior to the date on which the accounting is requested.

C. The Disclosure Log will track all disclosures except for the following:

1. To carry out treatment, payment and healthcare operations;
2. To individuals of protected health information about them;
3. Incident to a use or disclosure otherwise permitted or required in the CCMHS Use and Disclosure of PHI Policy and Procedure.
4. For a facility's directory, or to persons involved in the individual's care or other notification purposes in the CCMHS Use and Disclosure of PHI Policy and Procedure.
5. For national security or intelligence purposes.
6. To correctional institutions or law enforcement officials.
7. As part of a limited data set.
8. That occurred prior to the compliance date for CCMHS.

2. Request for Accounting of Disclosures

A. When a request for an accounting of disclosures is received from a person served:

1. The acceptability and credibility of the request will be determined.
2. If the request for accounting is accepted, the disclosure log will be prepared and distributed.
3. Medical records staff will be notified of the disclosure and will log the accounting of disclosure in the Medical Records Queue as described under 2.F. - Documentation of Accounting of Disclosure Requests.

B. The accounting must include the following information for the first disclosure:

1. Date of the disclosure.
2. Name and address (if known) of the organization or person who received the PHI.
3. Description of the PHI disclosed. This includes document type and date of service.
4. Brief statement of the purpose of the disclosure or a copy of the written request for disclosure.

5. Person(s) processing the requests.

C. The accounting must include the following information for subsequent and repeated disclosures of the same information to the same person or organization for a single purpose:

1. Date of the disclosure.
2. Name and address (if known) of the organization or person who received the PHI.
3. Description of the PHI disclosed. This includes document type and date of service.
4. Brief statement of the purpose of the disclosure or a copy of the written request for disclosure.
5. Person(s) processing the requests.
6. Frequency or number of disclosures made during the accounting period.
7. Date of the last disclosure made during the accounting period.

D. Timelines for providing the accounting

1. Provide the accounting to the requesting party as soon as is reasonably possible, but no later than sixty (60) days after the receipt of the request. Document the date of receipt by date stamping any paper request.
2. If unable to comply with the sixty (60) day rule the response period may be extended by thirty (30) days by sending the requesting party a written statement of the reasons for the delay and the date CCMHS will provide the accounting.

E. Costs for the accounting.

1. CCMHS will provide one accounting every twelve (12)-month period commencing with the date of the first request.
2. For any subsequent, individuals must be notified in advance of the fee and must provide the requesting party the opportunity to withdraw or modify their request to eliminate or reduce said fee.

F. Documentation of accounting of disclosure requests.

1. Medical Records Staff will document all accounting of disclosures of PHI in the Medical Records Queue. The following information will be logged regarding the disclosure:

    a. Date of the accounting of disclosure written request.
    b. Name and address (if known) of the organization or person requesting the accounting of disclosure of PHI.
    c. Description of the PHI disclosed. This includes document type(s) and date(s) of service.
    d. Brief statement of the purpose of the disclosure or a copy of the written request for disclosure.
    e. Person(s) processing the requests.
    f. The time period of the accounting of disclosure provided.

LEGAL AUTHORITY

A. Michigan Department of Health and Human Services Administrative Rules Section R 330.7051 Rule 7051.

B. 45 CFR Part 164 Section 528.

APPENDIX 6

SUBJECT: COURT ORDER OR SUBPOENA OF A COURT OR ADMINISTRATIVE TRIBUNAL PROCEDURE

PROCEDURE:

When CCMHS receives a court order or subpoena either to appear or for records (duces tecum):

1. The Order/Subpoena is given to the Executive Director or designee.
2. CCMHS receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the PHI that has been requested, has been given notice to that request.
    a. That assurance must be a written statement demonstrating that the party requesting such information has made a good faith effort to provide written notice to the individual or that the individual's location is unknown and has mailed notice to the individual's last known address.
    b. The notice should include sufficient information about the litigation or proceeding for which the PHI is requested to permit the individual to raise an objection to the court or Administrative Tribunal.
    c. The time for the individual to raise objection to the court or administrative tribunal has elapsed, no objections were filed or the court or tribunal has resolved all objections filed by the individual.
    d. CCMHS can assume notice has been received if CCMHS receive satisfactory assurance demonstrating that there has been a qualified protective order issued.
3. CCMHS may notify Legal Counsel that records are the subject of an order/subpoena.
4. Legal Counsel may be provided a copy of the order/subpoena and shall notify CCMHS relative to whether the information must be disclosed under the Mental Health Code.
5. Not withstanding, a subpoena for duces tecum, a person's served PHI is considered confidential will not be released without signed authorization.

Authorizations

1. CCMHS shall determine if there is a valid authorization in the record.
2. In the absence of a valid authorization, CCMHS shall make a reasonable effort to notify the person served that her/his record is generally considered privileged and they should secure their own legal advice in that regard.
3. Since mental health records are confidential, there must be an

    authorization signed by a party with authority to authorize prior to the release of records.

Asserting Privilege

1. If the person served asserts privilege, CCMHS Legal Counsel shall notify the requesting party that privilege is asserted, assuming time permits.
2. In the event time does not permit notice to the requester, CCMHS or CCMHS Legal Counsel shall

communicate to the Court involved that privilege is asserted and shall appear at the time and place indicated in the event the subpoena is for production of the record at a specified Court hearing.

3. No records shall be disclosed or released.
4. Absent a valid release, the potential liability for releasing records outweighs any potential contempt hearing for not releasing the record.
5. Whenever a subpoena for records is received for any Court proceedings:
    a. CCMHS shall verify that the person served and/or his/her attorney is notified of the same.
    b. CCMHS cannot give legal advice to a person served regarding confidentiality or privilege and the person served should be advised to seek the advice of an attorney.
    c. Where the person served cannot be located, or in the event she/he claims privilege, CCMHS Legal Counsel shall be made aware of the subpoena in a timely manner and shall direct a response to the subpoena consistent with this Protocol.

Subpoenas for Personal Appearances

1. The affected employee shall notify her/his supervisor who will in turn notify CCMHS Legal Counsel.
2. Decision to quash subpoena will be made on a case-by-case basis.

For case record entries made subsequent to March 28, 1996, PHI made confidential by this Section shall be disclosed to an adult, upon request by the person served, if the person served does not have a guardian and has not been adjudicated legally incompetent. The holder of the record shall comply with the adult's request for disclosure as expeditiously as possible but in no event later than the earlier of 30 days after receipt of the request or, if the person served is receiving treatment from the holder of the record, before the person served is released from treatment. Unless section 748(4) of the act applies to the request for PHI, the director of the provider may make a determination that disclosure of PHI may be detrimental to the person served or others.

Abuse/Neglect Cases

1. In abuse/neglect cases, if the Family Court has jurisdiction over minor children, and if CCMHS has conducted a court-ordered examination, interview of course of treatment, any PHI relating thereto must be released upon receipt of a subpoena in that proceeding.
2. Court ordered treatment means that an examination, interview or course of treatment commences on and after date of the Court Order. A court cannot order a parent or child to receive any examination, interview, or course of treatment unless it has jurisdiction. (This excludes emergency mental health treatment or hospitalization).
3. The release of information pursuant to an order/subpoena applies only to the person or persons who have been ordered to receive any form of service and therefore equally applies to adults (parents) under the Subpoena Procedure for Adults.

For any questions concerning the interpretation of this procedure, refer to the Privacy Officer or Legal Counsel.

LEGAL AUTHORITY

A. Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 748 (a), and 750.

B. 45 CFR Part 164 Section 512 (e).

APPENDIX 7

SUBJECT: DISCLOSURES TO PROTECTION AND ADVOCACY PROCEDURE

PROCEDURE:

A. An identified representative of Disability Rights Michigan shall be granted access to records in accordance with Public Law 94-103, 89 Stat. 486, Public Law 99-319, 100 Stat. 478, and Act 258 of the Public Acts of 1974, as amended. This includes:

1. If the person served, the guardian of the person served with authority to consent, or a parent of minor with legal and physical custody of the minor has consented to the access;

2. A person served, including a person served who has died or whose whereabouts are unknown, if all of the following apply:

   a. Because of mental or physical condition, the person served is unable to consent to the access;

   b. The person served does not have a guardian or other legal representative, or the guardian of the person served is the state;

   c. Disability Rights Michigan has received a complaint on behalf of the person served or has probable cause to believe based on monitoring or other evidence that the person served has been subject to abuse or neglect;

3. A person served who has a guardian or other legal guardian if all of the following apply:

   a. A complaint has been received by Disability Rights Michigan or there is probable cause to believe the health or safety of the person served is in serious and immediate jeopardy;

   b. Upon receipt of the name and address of the legal representative of the person served, Disability Rights Michigan has contacted the representative and offered assistance in resolving the situation;

   c. The representative has failed or refused to act on behalf of the person served.

LEGAL AUTHORITY

Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 748 (a), and 750.

APPENDIX 8

SUBJECT: REVIEW FOR DETRIMENT PROCEDURE

PROCEDURE:

A. Request for Access

When the records department receives any request for access, it will be given to the authorized clinician who processes the request. If CCMHS does not maintain the PHI that is the subject of the request of the person served and CCMHS knows where the requested information is maintained, the person served or legal representative must be informed where to direct their request for access.

B. Analysis of Person Served Status

An Authorized clinician determines whether the person served is a competent adult and entitled to receive his or her entire record under Mental Heath Code Sec. 748(4) or the person served is a legally incapacitated adult with guardian or a minor and a determination of detriment may be made.

C. Review for Detriment Process

If a review of detriment is appropriate (see Appendix 2) then the authorized clinician in conjunction with his or her clinical supervisor will perform such review under the following guidelines.

1. Authorized clinician has determined in the exercise of professional judgment that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
2. The PHI makes reference to another person and the authorized clinician has determined in the exercised professional judgment that the access requested is reasonably likely to cause substantial harm to such other person.
3. Request for access is made by the individual's personal representative and the authorized clinician in the exercise of professional judgment has determined that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

In all cases a determination of detriment shall not be made if the benefit to the person served from the disclosure outweighs the detriment.

D. Authorization by the Executive Director

The authorized clinician will send a written statement to the Executive Director outlining what information is to be withheld and why. The Executive Director or designee will make the final determination.

E. Implementation and Process for Denial of Access

If CCMHS denies access in whole or in part, the following requirements must be complied with:

1. CCMHS must to the extent possible give the individual access to any other PHI requested after excluding the PHI which has been denied;
2. CCMHS must provide a timely written denial to the person served;

3. The denial must be in plain language and must state the basis for denial;
4. The denial must also contain a description of how the person served may complain to the rights office and request a review of the denial from CCMHS or CMS.

F. Timeframes

If the record of the person served is located at the site where the request is made, the determination of detriment will be made within 3 business days of the request for access. If the record of the person served is located in another site, the determination of detriment will be made within 10 business days of the request for access.

G. Request for Review of Denial of Access

1. All requests for review of denial of access shall be forwarded to the rights office/privacy officer.
2. The rights office/privacy officer will ensure that a licensed health care professional who is not directly involved in the denial shall promptly provide a second opinion of the denial of access.
3. The licensed health care professional must determine within a reasonable period of time, not to exceed 10 business days, whether or not to uphold the denial of access. The licensed health care professional shall promptly inform the person served of the decision in writing.
4. If the person served is not satisfied with the final determination he or she can file a complaint with the Office of Recipient Rights.

LEGAL AUTHORITY

A. Act 258 of the Public Acts of 1974, as amended (Michigan Mental Health Code) Sections 748, 748 (a), and 750.

B. 45 CFR Part 164 Section 524.

APPENDIX 9

SUBJECT: A PERSON SERVED REQUEST FOR A RESTRICTION OF USES AND DISCLOSURES OF PHI PROCEDURE

PROCEDURE: Right Of An Individual To Request Restriction Of Uses And Disclosures

1. CCMHS must permit any person served to request in writing a restriction on any use or disclosure of protected health information for treatment, payment, health care operations, or to family member. CCMHS is not required to agree to the restriction, however if CCMHS does agree it must protect the person's served health information according to the agreed upon terms of the restriction.
2. Exceptions to adhering to an agreed upon restriction:
    a. In an emergency treatment situation, CCMHS may use or disclose previously restricted PHI that is necessary to provide emergency treatment. If CCMHS exercises its rights, it will request that the recipients of this information not further use or disclose it.
    b. Uses and disclosures to the Secretary of the Center for Medicare/Medicaid Services to investigate or determine CCMHS's compliance with the applicable local, state or federal law. If CCMHS agrees to such restrictions they are not enforceable under this rule.
3. CCMHS may terminate its agreement to a restriction, if:
    a. The individual agrees to or requests the termination in writing;
    b. The individual orally agrees to the termination and the oral agreement is documented; or
    c. CCMHS informs the individual that it is terminating its agreement to a restriction, except that such termination is only effective with respect to PHI created or received after it has so informed the individual.

Confidential Communications Requirements CCMHS must permit individuals to request and must accommodate reasonable requests by individuals to receive communications of PHI from CCMHS by alternative means or at alternative locations.

a. An individual must provide in writing, any request for confidential communications.
b. CCMHS may condition the provision of a reasonable accommodation on:
    i. When appropriate, information as to how payment, if any, will be handled; and
    ii. Specification of an alternative address or other method of contact.

LEGAL AUTHORITY: 45 CFR Part 164 Section 522.

APPENDIX 10

SUBJECT: VERIFICATION OF IDENTITY PROCEDURE

PROCEDURE:

Verification Requirements

1. Prior to any disclosure permitted CCMHS must:

    a. Except as otherwise required in CCMHS policies and procedures, CCMHS staff will verify the identity of a person requesting PHI and the authority of any such person to have access to PHI under CCMHS policies and procedures, if the identity or any such authority of such person is not known to CCMHS staff; and

    b. Obtain any documentation, statements, or representations, whether oral or written, from the person requesting the PHI when such documentation, statement or representation is a condition of the disclosure under CCMHS policies and procedures.

Verification Specifications

1. Conditions of Disclosures - If a disclosure is conditioned by CCMHS policies or procedures on particular documentation, statements or representations from the person requesting the PHI, CCMHS staff may rely, if such reliance is reasonable under such circumstances, on documentation, statements, or representations that, on their face, meet the applicable requirements.

2. Identity of Public Officials - CCMHS staff may rely, if such reliance is reasonable under the circumstances, on any of the following to verify identity when the disclosure of PHI is to a public official or a person acting on behalf of the public official:

    a. If the request is made in person, presentation of an agency identification badge, other official credentials, or other proof of government status;

    b. If the request is in writing, the request is on the appropriate government letterhead;

    c. If the disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency, such as a contract for services, memorandum of understanding, or purchase order, that establishes that the person is acting on behalf of the public official.

3. Authority of Public Officials - CCMHS staff may rely, if such reliance is reasonable under the circumstances, on any of the following to verify authority when the disclosure of PHI is to a public official or a person acting on behalf of the public official:

a. A written statement of the legal authority under which the information is requested or, if a written statement would be impracticable, an oral statement of such legal authority;

b. If a request is made pursuant to legal process, warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority.

4. Exercise of professional judgment - The verification requirements of this policy and procedure are met if CCMHS staff relies on the exercise of professional judgment in making a use or disclosure or acts on a good faith belief in making a disclosure in accordance with CCMHS policies and procedures.

LEGAL AUTHORITY

45 CFR Part 164 Section 514 (h) (1).

APPENDIX 11

SUBJECT: DE-IDENTIFIED INFORMATION PROCEDURE

PROCEDURE:

CCMHS staff will de-identify PHI of a person served in compliance with this policy and procedure when there is a need to release information in the absence of valid authorization or business associate agreement for the purposes of accreditation recording, public health, public policy initiatives, compliance audits, marketing and/or fundraising.

1. To release health information to a third party in the absence of a valid authorization or business associate agreement the following identifiers must be removed pertaining to the person served, relatives, employers, or household members of the person served:
   A. Names; Last, First, Middle Initial
   B. State, including street address, city, county, precinct, zip code.
   C. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death.
   D. Telephone numbers;
   E. Fax Numbers;
   F. E-Mail Addresses;
   G. Social Security Number;
   H. Medical Record Numbers;
   I. Health Plan Identification Numbers;
   J. Account Numbers;
   K. Certificate/License Numbers;
   L. Vehicle Identifiers and Serial Numbers;
   M. Device Identifier Numbers and Serial Numbers;
   N. Website Addresses and Uniform Resource Locators (URL's);
   O. Internet Protocol (IP) Address Numbers;
   P. Biometric Identifiers, including finger and voiceprints.
   Q. Full Face Photographic Images and Any Comparable Images; and
   R. Any Other Unique Identifying Number, Characteristic or Code.

2. Staff must not have actual knowledge that the information could be used alone or in combination with other information to identify a person served who is a subject of the information.

3. Release of de-identified person served information must be limited to that information which is the minimum necessary to meet the reason for the release of de-identified information.

APPENDIX 12

SUBJECT: HIPAA PRIVACY PRACTICES TRAINING PROCEDURE

PROCEDURE:

All CCMHS personnel will be trained on the policies and procedures with respect to PHI of the person served, as necessary and appropriate, for their position.

1. CCMHS will provide the required training as follows:
    a. To all new personnel within thirty (30) days of hire; and

    b. To all personnel whose functions are affected by a material change in the policies or procedures within a reasonable period of time after the material change becomes effective.

2. CCMHS will document that the training has been provided and retain the documentation for six (6) years from the date of its last creation or the date when it last was in effect, whichever is later.

LEGAL AUTHORITY:

45 CFR Part 164 Section 530(b)(2).

APPENDIX 13

SUBJECT: BUSINESS PARTNER/ASSOCIATE AGREEMENT PROCEDURE

PROCEDURE:

CCMHS may disclose PHI to a Business Associate and may allow a Business Associate to create or receive PHI on its behalf, if CCMHS obtains satisfactory assurance that the Business Associate will appropriately safeguard the information. CCMHS must document the satisfactory assurances required through a written contract or other written agreement or arrangement with the Business Associate.

This standard does not apply with respect to disclosures by CCMHS to a health care provider concerning the treatment of the individual.

A covered entity that violates the satisfactory assurances provided as a Business Associate of CCMHS will be in noncompliance with the standards, implementation specifications, and requirements.

CCMHS is not in compliance with the standards if CCMHS knew of a pattern of activity or practice of the Business Associate that constituted a material breach or violation of the Business Associate's obligation under the contract or other arrangement, unless CCMHS took reasonable steps to cure the breach or end the violation, as applicable, and, if such steps were unsuccessful:

1. Terminated the contract or arrangement, if feasible; or
2. If termination is not feasible, reported the problem to the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights.

A contract between the covered entity and a Business Associate must:

1. Establish the permitted and required uses and disclosures of the PHI. The contract may not authorize the Business Associate to use or further disclose the information in a manner that would violate the requirements of this subpart, if done by the covered entity, except that:
    a. The contract may permit the Business Associate to use and disclose PHI for the proper management and administration of the Business Associate; and
    b. The contract may permit the Business Associate to provide data aggregation services relating to the health care operations of the covered entity.
2. Provide that the Business Associate will:
    a. Not use or further disclose the PHI other than as permitted or required by the contract or as required by law;
    b. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the contract;
    c. Report to CCMHS any use or disclosure of the information not provided for by the contract of which it becomes aware;
    d. Ensure that any of its agents or subcontractors to whom it provides PHI received from or created or received by the Business Associate on behalf of, CCMHS agrees to the same restrictions and conditions that apply to the business associate with respect to such information.

e. Make the PHI available for inspection by the person served.

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Appendix 4;

g. Make available the information required to provide an accounting of disclosures in accordance with Appendix 5;

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by the Business Associate on behalf of, CCMHS available to the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights for purposes of determining CCMHS compliance with the business associate agreement;

i. At termination of the contract, if feasible, return or destroy all PHI received from, or created or received by the Business Associate on behalf of, CCMHS, that the Business Associate still maintains in any form and retain no copies of such information or if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to the purposes that make the return or destruction of the information infeasible.

3. Authorize termination of the contract by CCMHS if CCMHS determines that the Business Associate has violated a material breach of the contract.

LEGAL AUTHORITY

45 CFR Part 164 Section 502(e)(1) and 504(e)(1)

APPENDIX 14

SUBJECT: HIPAA SANCTION PROCEDURE

PROCEDURE:

CCMHS will protect the confidentiality and integrity of PHI and provide progressive sanctions for any substantiated failure to comply with any standards required by law, professional ethics, or accreditation standards.

CCMHS and its departments have adopted procedures and standards to carry out the objectives of this policy. All CCMHS personnel must adhere to these procedures and standards. All violations constitute grounds for disciplinary action up to and including termination, professional discipline, and criminal prosecution.

1. Duty To Report
   All CCMHS personnel are required to report any and all breaches of the CCMHS privacy and security policies and procedures. CCMHS personnel should immediately verbally report such breach to his or her supervisor and to the Privacy Officer and/or Security Officer or their designee, immediately and write an incident report within 24 hours.

2. Duty To Investigate
   The Privacy and/or Security Officer or designees will conduct a thorough and confidential investigation into the allegations. CCMHS will not retaliate against or permit reprisals against a complainant.

3. Sanction For A Substantiated Violation
   The CCMHS Corrective/Progressive Discipline Policy and Procedure shall be used to determine and apply appropriate sanctions.

Disclaimer: The Sanction Policy and Procedure is intended as a guide for the efficient and professional performance of employees' duties to protect the integrity and confidentiality of PHI. Nothing herein shall be construed to be a contract between the employer and the employee. Additionally, nothing in this Sanction Policy and Procedure is to be construed by any employee as containing binding terms and condition of employment. Nothing in this Sanction Policy should be construed as conferring any employment rights on employees or changing their status from "at-will employees." The organization retains the absolute right to terminate any employee, at any time, with or without good cause. Management retains the right to change the contents of this Sanction Policy and Procedure, as it deems necessary with or without notice.

LEGAL AUTHORITY:
45 CFR Part 164 Section 530 (e) (1)

COPPER COUNTRY MENTAL HEALTH SERVICES BOARD
POLICY AND PROCEDURES

DATE: July 31, 2013

RESCINDS: July 25, 2012

CATEGORY: Medical Services

SUBJECT: Use of Pharmacotherapy Treatment Guidelines

POLICY: It is the policy of the Copper Country Mental Health Services Board (CCMHS) that the most current standardized treatment protocols regarding pharmacotherapy are implemented.

PURPOSE: The purpose of this policy is to promote state-of-the-art service provision and safety to the persons served by CCMHS through the use of the pharmacotherapy treatment guidelines.

PROCEDURE:

I. Adoption: Physicians and nurse practitioners utilize the most current treatment protocols available to assist in providing state-of-the-art pharmacotherapy. Examples of sources could include: APA Practice Guidelines, Expert Consensus Guidelines, AACAP Practice Guidelines, SAMHSA website.

II. Training and Implementation: Physicians and nurse practitioners are required to receive continuing medical education that includes state-of-the-art pharmacotherapy. Physicians and nurse practitioners review medical journals and the training that each receives is used in their prescribing methods and to educate staff and persons served when appropriate.

CROSS REFERENCE:

N/A